110TH CONGRESS
1ST SESSION

S. 1019

To provide comprehensive reform of the health care system of the United States, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 28, 2007

Mr. COBURN (for himself, Mr. BURR, Mr. CHAMBLISS, and Mr. INHOFE) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide comprehensive reform of the health care system of the United States, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Universal Health Care Choice and Access Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Nine out of 10 Americans think the United States health care system needs fundamental changes.

(2) The United States spends approximately 16 percent of its Gross Domestic Product on health care and experts estimate that percentage will rise to 20 percent by 2015.

(3) The Federal Government spends more on health care than it does on national defense.

(4) As much as $1 out of every $4 health care dollars do not go towards making Americans healthy.

(5) Nearly 75 percent of American health care spending goes toward the treatment of chronic diseases. Five preventable chronic diseases (heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes) cause two-thirds of American deaths.

(6) Since 2000, premiums for family health coverage have increased by 87 percent, compared with cumulative inflation of 18 percent and cumulative wage growth of 20 percent. During this same period, the percentage of employers offering health benefits has fallen from 69 percent to 61 percent, and the percentage of workers covered by their own employer

also has fallen. The current employer-based system offers little choice in health plans to employees: 88 percent of American firms offer only 1 health plan type.

(7) Medicaid was designed as a safety net to ensure that the poorest Americans have access to health care at a cost of $1,000,000,000 in its first year. Today, more than 1 out of every 6 Americans is in Medicaid at a total cost of more than $338,000,000,000 in 2006. The program is expected to cost nearly $5,000,000,000,000 over the next decade. In 2003, for the first time ever, Medicaid spending replaced education as the largest component of State budgets, consuming 22 percent of State spending.

(8) The unfunded liabilities of the Medicare Program over the next 75 years are estimated to be $32,100,000,000,000 and $70,500,000,000,000 on the infinite horizon. The Federal Hospital Insurance Trust Fund is projected to be exhausted by 2018. Without any change in the program, Medicare will consume 23.1 percent of all Federal income taxes by 2020 and 37.5 percent of all Federal income taxes by 2030. Under the current system, physician reimbursements will be cut by 34 percent by the year

2015, leading to decreased access to physicians' services for seniors.

(9) Our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care. Economists estimate that between 5 and 9 percent of health care spending is related to defensive medicine.

(10) The adoption of health information technology will significantly reduce health care spending while simultaneously increasing the quality of health care.

TITLE I—PREVENTION AND WELLNESS

SEC. 101. STRATEGIC APPROACH TO OUTCOME-BASED PREVENTION.

(a) INTERAGENCY COORDINATING COMMITTEE.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the ''Secretary'') shall convene an interagency coordi-

nating committee to develop a national strategic plan for prevention. The Secretary shall serve as the chairperson of the committee.

(2) COMPOSITION.—In carrying out paragraph (1), the Secretary shall include the participation of—

(A) the Director of the National Institutes of Health;

(B) The Director of the Centers for Disease Control and Prevention;

(C) the Administrator of the Agency for Healthcare Research and Quality;

(D) the Administrator of the Substance Abuse and Mental Health Services Administration;

(E) the Administrator of the Health Resources and Services Administration;

(F) the Secretary of Agriculture;

(G) the Director of the Centers for Medicare & Medicaid Services;

(H) the Administrator of the Environmental Protection Agency;

(I) the Director of the Indian Health Service;

(J) the Administrator of the Administration on Aging;

(K) the Secretary of Veterans Affairs;

(L) the Secretary of Defense;

(M) the Secretary of Education; and

(N) the Secretary of Labor.

(3) REPORT AND PLAN.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the coordinating committee convened under paragraph (1), shall submit to Congress a report concerning the recommendation of the committee for health promotion and disease prevention activities. Such report shall include a specific strategic plan that shall include—

(A) a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, and appropriate exercise) and the prevention measures for the 5 leading disease killers in the United States;

(B) specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, and smoking cessation, and targeting the 5 leading disease killers in the United States;

(C) specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Health People 2010), that include transferring the nutrition guideline development responsibility from the Secretary of Agriculture to the Director of the Centers for Disease Control and Prevention;

(D) specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations promulgated by the Director of the Centers for Disease Control and Prevention;

(E) specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under subparagraph (D); and

(F) a list of new non-Federal and non-government partners identified by the committee to build Federal capacity in health promotion and disease prevention efforts.

(4) ANNUAL REQUEST TO GIVE TESTIMONY.—The Secretary shall annually request an opportunity to testify before Congress concerning the progress made by the United States in meeting the outcome-based standards of Healthy People 2010 with respect to disease prevention and measurable outcomes and effectiveness of Federal programs related to this goal.

(5) PERIODIC REVIEWS.—The Secretary shall conduct periodic reviews, not less than every 5 years, and grading of every Federal disease prevention and health promotion initiatives, programs, and agencies. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies' public Internet websites.

(b) FEDERAL MESSAGING ON HEALTH PROMOTION AND DISEASE PREVENTION.—

(1) MEDIA CAMPAIGNS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(B) REQUIREMENTS OF CAMPAIGN.—The campaign implemented under subparagraph (A)—

(i) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening promotion;

(ii) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(iii) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(iv) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(v) may include the use of humor and nationally-recognized positive role models.

(C) EVALUATION.—The Secretary shall ensure that the campaign implemented under sub-

paragraph (A) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(2) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(3) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities described in the strategic and implementing plan under subsection (a)(3)(A), through health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and

Services Administration, and the Medicare and Medicaid Programs.

(4) PERSONALIZED PREVENTION PLANS.—

(A) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(B) USE.—The website developed under subparagraph (A) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(5) INTERNET PORTAL.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(6) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funding from the Centers for Disease Control and Prevention provided for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed $500,000,000 shall be expended on the campaigns and activities required under this Act.

SEC. 102. STATE GRANTS FOR OUTCOME-BASED PREVENTION EFFORT.

(a) IN GENERAL.—If the Secretary determines that it is essential to meeting the national priorities described in the plan required under section 101(a)(3)(A), the Secretary may award grants to States for the conduct of specific health promotion and disease prevention activities.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a strategic plan that shall—

(1) describe the specific health promotion and disease prevention activities to be carried out under this grant;

(2) include a list of the barriers that exist within the State to meeting specific goals of Healthy People 2010;

(3) include targeted demographic indicators and measurable objectives with respect to health promotion and disease prevention;

(4) contain a set of process outcomes and milestones, based on the process outcomes and milestones developed by the Secretary, for measuring the effectiveness of activities carried out under the grant in the State; and

(5) outline the manner in which interventions to be carried out under this grant will reduce morbidity and mortality within the State over a 5-year period (or over a 10-year period, if the Secretary determines such period appropriate for adequately measuring progress).

(c) PROCESS OUTCOMES AND MILESTONES.—

(1) IN GENERAL.—The Secretary shall develop process outcomes and milestones to be used to measure the effectiveness of activities carried out under a grant under this section by a State.

(2) DETERMINATIONS.—If, beginning 2 years after the date on which a grant is awarded to a State under this section, the Secretary determines

that the State is failing to make adequate progress in meeting the outcomes and milestones contained in the State plan under subsection (b)(4), the Secretary shall provide the State with technical assistance on how to make such progress. Such technical assistance shall continue for a period of 2 years.

(3) CONTINUED FAILURE TO MEET OBJECTIVES.—If after the expiration of the 2-year period described in paragraph (2), the Secretary determines that the State is failing to make adequate progress in meeting the outcomes and milestones contained in the State plan under subsection (b)(4) over a 5-year period, the Secretary shall terminate all funding to the State under a grant under this section.

(d) REGIONAL ACTIVITIES.—A State may use an amount, not to exceed 15 percent of the total grant amount to such State, to carry out regional activities in conjunction with other States.

(e) TARGETED ACTIVITIES.—A State may use grant funds to target specific populations within the State to achieve specific outcomes described in Healthy People 2010.

(f) INNOVATIVE INCENTIVE STRUCTURES.—The Secretary may award grants to States for the purposes of developing innovative incentive structures to encourage indi-

viduals to adopt specific prevention behaviors such as reducing their body mass index or for smoking cessation.

(g) WELLNESS BONUSES.—

(1) IN GENERAL.—The Secretary shall award wellness bonus payments to at least 5, but not more than 10, States that demonstrate the greatest progress in reducing disease rates and risk factors and increasing heathy behaviors.

(2) REQUIREMENT.—To be eligible to receive a bonus payment under paragraph (1), a State shall demonstrate—

(A) the progress described in paragraph (1); and

(B) that the State has met a specific floor for progress outlined in the science-based metrics of Healthy People 2010.

(3) USE OF PAYMENTS.—Bonus payments under this subsection may only be used by a State for the purposes of health promotion and disease prevention.

(4) FUNDING.—Out of funds appropriated to the Director of the Centers for Disease Control and Prevention for each fiscal year beginning with fiscal year 2008, the Director shall give priority to using

$50,000,000 of such funds to make bonus payments under this subsection.

(h) ADMINISTRATIVE EXPENSES.—A State may use not more than 5 percent of the amount of a grant under this section to carry out administrative activities.

(i) STATE.—In this section, the term ''State'' means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

(j) AUTHORIZATION OF APPROPRIATIONS.—Funding for the activities authorized under this section shall take priority over funding from the Centers for Disease Control and Prevention provided for grants to States and other entities for similar purposes and goals as provided for in this section, not to exceed $300,000,000 for each fiscal year.

SEC. 103. KEEPING THE FOOD STAMP PROGRAM FOCUSED ON NUTRITION.

(a) COUNSELING BROCHURE.—The Director of the Centers for Disease Control and Prevention shall develop, and the Secretary of Agriculture shall distribute to each individual and family enrolled in the Food Stamp Program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.), a science-based nutrition counseling brochure.

(b) LIMITATIONS ON FOOD STAMP PURCHASES.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Agriculture shall, based on scientific, peer-reviewed recommendations provided by a Commission that includes public health, medical, and nutrition experts and the Director of the Centers for Disease Control and Prevention, develop lists of foods that do not meet science-based standards for proper nutrition and that may not be purchased under the food stamp program. Such list shall be updated on an annual basis to ensure the most current science-based recommendations are applied to the food stamp program.

(2) AUTOMATED ENFORCEMENT.—The Secretary of Agriculture shall, through regulations, ensure that the limitations on food purchases under paragraph (1) is enforced through the food stamp program's automated system.

(3) IMPLEMENTATION.—The Secretary of Agriculture shall promulgate the regulations described in paragraph (2) by the date that is not later than 1 year after the date of enactment of this section.

SEC. 104. IMMUNIZATIONS.

(a) PURCHASE OF VACCINES.—Notwithstanding any other provision of law, a State may use amounts provided under section 317 of the Public Health Service Act (42 U.S.C. 247b) for immunization programs to purchase vaccines for use in health care provider offices and schools.

(b) TECHNICAL ASSISTANCE AND REDUCTION IN FUNDING.—If a State does not achieve a benchmark of 80 percent coverage within the State for Centers for Disease Control and Prevention-recommended vaccines, the Director of the Centers shall provide technical assistance to the State for a period of 2 years. If after the expiration of such 2-year period the State continues to fail to achieve such benchmark, the Secretary shall reduce funding provided under section 317 of the Public Health Service Act to such State by 5 percent.

(c) BONUS GRANT.—A State achieving a benchmark of 90 percent or greater coverage within the State for Centers for Disease Control and Prevention-recommended vaccines shall be eligible for a bonus grant from amounts appropriated under subsection (d).

(d) AUTHORIZATION OF APPROPRIATIONS.—Out of funds appropriated to the Director of the Centers for Disease Control and Prevention for each fiscal year beginning with fiscal year 2008, there shall be made available to carry out this section, $50,000,000 for each fiscal year.

(e) FUNDING FOR SECTION 317.—Section 317(j)(1) of the Public Health Service Act (42 U.S.C. 247b(j)(1)) is amended by striking ''2005'' and inserting ''2010''.

TITLE II—TAX INCENTIVES TO ENCOURAGE PURCHASE OF HEALTH CARE INSURANCE

Subtitle A—Health Savings Accounts

SEC. 201. EXPANSION OF HEALTH SAVINGS ACCOUNTS.

(a) INCREASE IN MONTHLY CONTRIBUTION LIMIT.—

(1) IN GENERAL.—Paragraph (2) of section 223(b) of the Internal Revenue Code of 1986 (relating to limitations) is amended to read as follows:

''(2) MONTHLY LIMITATION.—

''(A) IN GENERAL.—In the case of an eligible individual who has coverage under a high deductible health plan, the monthly limitation for any month of such coverage is 1/12 of the sum of—

''(i) the greater of—

''(I) the sum of the annual deductible and the other annual out-of-pocket expenses (other than for premiums) required to be paid under the

plan by the eligible individual for covered benefits, or

"(II) in the case of an eligible individual who has—

"(aa) self-only coverage under a high deductible health plan as of the first day of such month, $2,250, or

"(bb) family coverage under a high deductible health plan as of the first day of such month, $4,500, and

"(ii) in the case of an eligible individual who has coverage under a qualified long-term care insurance contract (as defined in section 7702B(b)), the lesser of—

"(I) the annual premium for such coverage, or

"(II) $1,000.

"(B) SPECIAL RULES RELATING TO OUT-OF-POCKET EXPENSES.—

"(i) REDUCTION FOR SEPARATE PLAN.—The annual out-of-pocket expenses taken into account under subparagraph (A)(i)(I) with respect to any eligible indi-

vidual shall be reduced by any out-of-pocket expense payable under a separate plan covering the individual.

''(ii) SECRETARIAL AUTHORITY.—The Secretary may by regulations provide that annual out-of-pocket expenses will not be taken into account under subparagraph (A)(i)(I) to the extent that there is only a remote likelihood that such amounts will be required to be paid.''.

(2) APPLICATION OF SPECIAL RULES FOR MARRIED INDIVIDUALS.—Paragraph (5) of section 223(b) of such Code (relating to limitations) is amended to read as follows:

''(5) SPECIAL RULES FOR MARRIED INDIVIDUALS.—

''(A) IN GENERAL.—In the case of individuals who are married to each other and who are both eligible individuals, the limitation under paragraph (1) for each spouse shall be equal to the spouse's applicable share of the combined marital limit.

''(B) COMBINED MARITAL LIMIT.—For purposes of subparagraph (A), the combined marital limit is the excess (if any) of—

"(i) the lesser of—

"(I) subject to subparagraph (C), the sum of the limitations computed separately under paragraph (1) for each spouse (including any additional contribution amount under paragraph (3)), or

"(II) the dollar amount in effect under subsection (c)(2)(A)(ii)(II), over

"(ii) the aggregate amount paid to Archer MSAs of such spouses for the taxable year.

"(C) SPECIAL RULE WHERE BOTH SPOUSES HAVE FAMILY COVERAGE.—For purposes of subparagraph (B)(i)(I), if either spouse has family coverage which covers both spouses, both spouses shall be treated as having only such coverage (and if both spouses each have such coverage under different plans, shall be treated as having only family coverage with the plan with respect to which the lowest amount is determined under paragraph (2)(A)(i)(I)).

"(D) APPLICABLE SHARE.—For purposes of subparagraph (A), a spouse's applicable

share is ½ of the combined marital limit unless both spouses agree on a different division.

''(E) COUPLES NOT MARRIED ENTIRE YEAR.—The Secretary shall prescribe rules for the application of this paragraph in the case of any taxable year for which the individuals were not married to each other during all months included in the taxable year, including rules which allow individuals in appropriate cases to take into account coverage prior to marriage in computing the combined marital limit for purposes of this paragraph.''.

(3) SELF-ONLY COVERAGE.—Paragraph (4) of section 223(c) of such Code (relating to definitions and special rules) is amended to read as follows:

''(4) COVERAGE.—

''(A) FAMILY COVERAGE.—The term 'family coverage' means any coverage other than self-only coverage.

''(B) SELF-ONLY COVERAGE.—If more than 1 individual is covered by a high deductible health plan but only 1 of the individuals is an eligible individual, the coverage shall be treated as self-only coverage.''.

(4) CONFORMING AMENDMENTS.—

(A) Section 223(b)(3)(A) of such Code is amended by striking ''subparagraphs (A) and (B) of''.

(B) Section 223(d)(1)(A)(ii)(I) of such Code is amended by striking ''subsection (b)(2)(B)(ii)'' and inserting ''subsection (c)(2)(A)(ii)(II)''.

(C) Clause (ii) of section 223(c)(2)(D) of such Code is amended to read as follows:

''(ii) CERTAIN ITEMS DISREGARDED IN COMPUTING MONTHLY LIMITATION.—Such plan's annual deductible, and such plan's annual out-of-pocket limitation, for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).''

(D) Subsection (g) of section 223 of such Code is amended to read as follows:

''(g) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2008, each dollar amount contained in subsections (b)(2)(A) and (c)(2)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under paragraph (2) for the calendar year in which such taxable year begins.

''(2) COST-OF-LIVING ADJUSTMENT.—For purposes of paragraph (1), the cost-of-living adjustment for any calendar year is the percentage (if any) by which—

''(A) the GDP for the preceding calendar year, exceeds

''(B) the GDP—

''(i) for calendar year 1997, in the case of each dollar amount in subsection (b)(2)(A)(i),

''(ii) for calendar year 2007, in the case of the dollar amount in subsection (b)(2)(A)(ii), and

''(iii) for calendar year 2003 in the case of each dollar amount in subsection (c)(2)(A).

''(3) GDP FOR ANY CALENDAR YEAR.—For purposes of paragraph (2), the GDP for any calendar year is the average of the chain-weighted price index for the gross domestic product as of the close of the 12-month period ending on March 31 of such calendar year.

''(4) CHAIN-WEIGHTED PRICE INDEX FOR THE GROSS DOMESTIC PRODUCT.—For purposes of paragraph (3), the term 'chain-weighted price index for the gross domestic product' means the last chain-weighted price index for the gross domestic product published by the Department of Commerce.

''(5) ROUNDING.—Any increase determined under paragraph (1) shall be rounded to the nearest multiple of $50.''.

(b) USE OF ACCOUNT FOR INDIVIDUAL HIGH DEDUCTIBLE HEALTH PLAN PREMIUMS.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 (relating to exceptions) is amended by striking ''or'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', or'', and by adding at the end the following new clause:

''(v) a high deductible health plan, but only if—

''(I) the plan is not a group health plan (as defined in section 5000(b)(1) without regard to section 5000(d)), and

''(II) the expenses are for coverage for a month with respect to which the account beneficiary is an el-

igible individual by reason of the coverage under the plan.

For purposes of clause (v), an arrangement which constitutes individual health insurance shall not be treated as a group health plan, notwithstanding that an employer or employee organization negotiates the cost of benefits of such arrangement.''.

(c) SAFE HARBOR FOR ABSENCE OF MAINTENANCE OF CHRONIC DISEASE.—Section 223(c)(2)(C) of the Internal Revenue Code of 1986 (safe harbor for absence of preventive care deductible) is amended—

(1) by inserting ''or maintenance of chronic disease, or both'' after ''the Secretary)'', and

(2) by inserting ''OR MAINTENANCE OF CHRONIC DISEASE'' in the heading after ''PREVENTIVE CARE''.

(d) CLARIFICATION OF TREATMENT OF CAPITATED PRIMARY CARE PAYMENTS AS AMOUNTS PAID FOR MEDICAL CARE.—Section 213(d) of the Internal Revenue Code of 1986 (relating to definitions) is amended by adding at the end the following new paragraph:

''(12) TREATMENT OF CAPITATED PRIMARY CARE PAYMENTS.—Capitated primary care payments shall be treated as amounts paid for medical care.''.

(e) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR VETERANS OR INDIAN HEALTH BENEFITS.—Section 223(c)(1) of the Internal Revenue Code of 1986 (defining eligible individual) is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR VETERANS OR INDIAN HEALTH BENEFITS.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual receives periodic hospital care or medical services under any law administered by the Secretary of Veterans Affairs or the Bureau of Indian Affairs.''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2007.

(2) CAPITATED PRIMARY CARE PAYMENTS.—The amendment made by subsection (d) shall apply to amounts paid before, on, or after the date of the enactment of this Act.

SEC. 202. EXCEPTION TO REQUIREMENT FOR EMPLOYERS TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.

(a) GREATER EMPLOYER-PROVIDED CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES TREATED AS MEETING COMPARABILITY REQUIREMENTS.—Subsection (b) of section 4980G of the Internal Revenue Code of 1986 (relating to failure of employer to make comparable health savings account contributions) is amended to read as follows:

''(b) RULES AND REQUIREMENTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), rules and requirements similar to the rules and requirements of section 4980E shall apply for purposes of this section.

''(2) TREATMENT OF EMPLOYER-PROVIDED CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES.—For purposes of this section—

''(A) IN GENERAL.—Any contribution by an employer to a health savings account of an employee who is (or the spouse or any dependent of the employee who is) a chronically ill individual in an amount which is greater than a contribution to a health savings account of a comparable participating employee who is not a

chronically ill individual shall not fail to be considered a comparable contribution.

''(B) NONDISCRIMINATION REQUIREMENT.—Subparagraph (A) shall not apply unless the excess employer contributions described in subparagraph (A) are the same for all chronically ill individuals who are similarly situated.

''(C) CHRONICALLY ILL INDIVIDUAL.—For purposes of this paragraph, the term 'chronically ill individual' means any individual whose qualified medical expenses for any taxable year are more than 50 percent greater than the average qualified medical expenses of all employees of the employer for such year.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

Subtitle B—MediChoice Tax Rebates

SEC. 211. REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redes-

ignating section 36 as section 37 and by inserting after section 35 the following new section:

"SEC. 36. MEDICHOICE TAX REBATES.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the amount paid during the taxable year for qualified health insurance for the taxpayer and the taxpayer's spouse or dependent.

"(b) LIMITATIONS.—

"(1) IN GENERAL.—The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the sum of the monthly limitations for coverage months during such taxable year for the individual referred to in subsection (a) for whom the taxpayer paid during the taxable year any amount for coverage under qualified health insurance.

"(2) MONTHLY LIMITATION.—

"(A) IN GENERAL.—The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to 1/12 of the qualified health insurance amount.

"(B) QUALIFIED HEALTH INSURANCE AMOUNT.—For purposes of this paragraph, the qualified health insurance amount is—

"(i) $2,000 if such individual is the taxpayer,

"(ii) $2,000 if such individual is the spouse of the taxpayer, the taxpayer and such spouse are married as of the first day of such month, and the taxpayer files a joint return for the taxable year, or

"(iii) $500 if such individual is an individual for whom a deduction under section 151(c) is allowable to the taxpayer for such taxable year.

"(C) LIMITATION ON DEPENDENTS.—Not more than 2 individuals may be taken into account by the taxpayer under subparagraph (B)(iii).

"(3) COVERAGE MONTH.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'coverage month' means, with respect to an individual, any month if—

"(i) as of the first day of such month such individual is covered by qualified health insurance, and

"(ii) the premium for coverage under such insurance for such month is paid by the taxpayer.

"(B) MEDICARE.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual has not made an election to establish and maintain a Medical Retirement Account under section 252(a)(2) of the Social Security Act and is entitled to benefits under title XVIII of the Social Security Act.

"(C) CERTAIN OTHER COVERAGE.—Such term shall not include any month during a taxable year with respect to an individual if, at any time during such year, any benefit is provided to such individual under—

"(i) chapter 55 of title 10, United States Code,

"(ii) chapter 17 of title 38, United States Code, or

"(iii) any medical care program under the Indian Health Care Improvement Act.

''(D) PRISONERS.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

''(E) INSUFFICIENT PRESENCE IN UNITED STATES.—Such term shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

''(c) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance' means any health plan (within the meaning of section 223(c)(2)) determined without regard to any annual deductible requirement.

''(2) ANNUAL WELLNESS EXAM.—Such term shall include an annual wellness exam fee not to exceed $150 ($100 in the case of an annual child wellness exam) if such exam is not covered by the insurance.

''(d) ARCHER MSA AND HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—

''(1) IN GENERAL.—If a deduction would (but for paragraph (2)) be allowed under section 220 or 223 to the taxpayer for a payment for the taxable year to the Archer MSA or health savings account of an individual, subsection (a) shall be applied by treating such payment as a payment for qualified health insurance for such individual.

''(2) DENIAL OF DOUBLE BENEFIT.—No deduction shall be allowed under section 220 or 223 for that portion of the payments otherwise allowable as a deduction under section 220 or 223 for the taxable year which is equal to the amount of credit allowed for such taxable year by reason of this subsection.

''(e) SPECIAL RULES.—For purposes of this section—

''(1) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

''(2) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a tax-

able year beginning in the calendar year in which such individual's taxable year begins.

''(3) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under subsection (a) if the credit under section 35 is allowed and no credit shall be allowed under 35 if a credit is allowed under this section.

''(4) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS.—In the case of a taxpayer who is eligible to deduct any amount under section 162(l) or 213 for the taxable year, this section shall apply only if the taxpayer elects not to claim any amount as a deduction under such section for such year.

''(5) ELECTION NOT TO CLAIM CREDIT.—This section shall not apply to a taxpayer for any taxable year if such taxpayer elects to have this section not apply for such taxable year.

''(6) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2008, each dollar amount contained in subsection (b)(2)(B) shall be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) the cost-of-living adjustment determined under subparagraph (B) for the calendar year in which such taxable year begins.

''(B) COST-OF-LIVING ADJUSTMENT.—For purposes of subparagraph (A), the cost-of-living adjustment for any calendar year is the percentage (if any) by which—

''(i) the GDP for the preceding calendar year, exceeds

''(ii) the GDP for calendar year 2007.

''(C) GDP FOR ANY CALENDAR YEAR.—For purposes of subparagraph (B), the GDP for any calendar year is the average of the chain-weighted price index for the gross domestic product as of the close of the 12-month period ending on March 31 of such calendar year.

''(D) CHAIN-WEIGHTED PRICE INDEX FOR THE GROSS DOMESTIC PRODUCT.—For purposes of subparagraph (C), the term 'chain-weighted price index for the gross domestic product' means the last chain-weighted price index for the gross domestic product published by the Department of Commerce.

''(E) ROUNDING.—Any increase determined under subparagraph (A) shall be rounded to the nearest multiple of $50.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050V the following new section:

''SEC. 6050W. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

''(a) IN GENERAL.—Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such individual or any other individual under creditable health insurance, shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

"(A) the name, address, and TIN of the individual from whom payments described in subsection (a) were received,

"(B) the name, address, and TIN of each individual who was provided by such person with coverage under creditable health insurance by reason of such payments and the period of such coverage, and

"(C) such other information as the Secretary may reasonably prescribe.

"(c) CREDITABLE HEALTH INSURANCE.—For purposes of this section, the term 'creditable health insurance' means qualified health insurance (as defined in section 36(c)) other than, to the extent provided in regulations prescribed by the Secretary, any insurance covering an individual if no credit is allowable under section 36 with respect to such coverage.

"(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

''(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

''(3) the information required under subsection (b)(2)(B) with respect to such payments.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(e) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xv) through (xx) as clauses (xvi) through (xxi), re-

spectively, and by inserting after clause (xi) the following new clause:

"(xv) section 6050W (relating to returns relating to payments for qualified health insurance),".

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking the period at the end of subparagraph (CC) and inserting ", or" and by adding at the end the following new subparagraph:

"(DD) section 6050W(d) (relating to returns relating to payments for qualified health insurance).".

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050V the following new item:

"Sec. 6050W. Returns relating to payments for qualified health insurance.".

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period ", or from section 36 of such Code".

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Rev-

enue Code of 1986 is amended by striking the last item and inserting the following new items:

"Sec. 36. MediChoice tax rebates.
"Sec. 37. Overpayments of tax.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 212. ADVANCE PAYMENT OF CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

"SEC. 7529. ADVANCE PAYMENT OF MEDICHOICE TAX REBATES.

"(a) GENERAL RULE.—In the case of an eligible individual, the Secretary shall make payments to the provider of such individual's qualified health insurance equal to such individual's qualified health insurance credit advance amount with respect to such provider.

"(b) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual—

"(1) who purchases qualified health insurance (as defined in section 36(c)), and

''(2) for whom a qualified health insurance credit eligibility certificate is in effect.

''(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to the Secretary which—

''(1) certifies that the individual will be eligible to receive the credit provided by section 36 for the taxable year,

''(2) estimates the amount of such credit for such taxable year, and

''(3) provides such other information as the Secretary may require for purposes of this section.

''(d) QUALIFIED HEALTH INSURANCE CREDIT ADVANCE AMOUNT.—For purposes of this section, the term 'qualified health insurance credit advance amount' means, with respect to any provider of qualified health insurance, the Secretary's estimate of the amount of credit allowable under section 36 to the individual for the taxable year which is attributable to the insurance provided to the individual by such provider.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 7529. Advance payment of MediChoice tax rebates.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 213. TERMINATION OF EMPLOYER-PROVIDED HEALTH CARE COVERAGE EXCLUSION.

(a) IN GENERAL.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

''(e) TERMINATION OF EMPLOYER-PROVIDED HEALTH CARE COVERAGE EXCLUSION.—

''(1) IN GENERAL.—The amount of any exclusion under subsection (a) for any taxable year beginning after December 31, 2007, with respect to—

''(A) any employer-provided coverage under an accident or health plan which constitutes medical care, and

''(B) any employer contribution to an Archer MSA or a health savings account which is treated by subsection (b) or (d) as employer-provided coverage for medical expenses under an accident or health plan,

shall be zero.

''(2) MEDICAL CARE DEFINED.—For purposes of paragraph (1), the term 'medical care' has the meaning given to such term in section 213(d) determined without regard to—

''(A) paragraph (1)(C) thereof, and

''(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.''.

(b) TERMINATION OF HEALTH CARE EXPENSE REIMBURSEMENT UNDER CAFETERIA PLANS.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsection (h) as subsection (i) and by inserting after subsection (g) the following new subsection:

''(h) TERMINATION.—This section shall not apply to health benefits coverage in any taxable year beginning after December 31, 2007.''.

(c) TERMINATION OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—The table contained in section 162(l)(1)(B) of the Internal Revenue Code of 1986 (relating to applicable percentage) is amended by striking ''and thereafter'' and inserting ''through 2007''.

(d) PAYROLL TAXES.—

(1) IN GENERAL.—Section 3121(a) of the Internal Revenue Code of 1986 (defining wages) is amended by adding at the end the following new sentence: ''In the case of any calendar year beginning after December 31, 2007, paragraphs (2) and (4) shall not apply to payments on account of sickness.''.

(2) RAILROAD RETIREMENT.—Section 3231(e)(1) of such Code (defining wages) is amended by adding at the end the following new sentence: ''In the case of any calendar year beginning after December 31, 2007, this paragraph shall not apply to payments on account of sickness.''.

(3) UNEMPLOYMENT.—Section 3306(b) of such Code (defining wages) is amended by adding at the end the following new sentence: ''In the case of any calendar year beginning after December 31, 2007, paragraphs (2) and (4) shall not apply to payments on account of sickness.''.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2007.

(2) PAYROLL TAXES.—The amendments made by subsection (d) shall apply to calendar years beginning after December 31, 2007.

TITLE III—HEALTH INSURANCE MODERNIZATION

Subtitle A—Employee Choice

SEC. 301. CLARIFICATION OF DEFINITION OF GROUP HEALTH PLAN UNDER HIPAA.

(a) ERISA.—Section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)) is amended by adding at the end the following: ''Such term does not include an arrangement maintained by an employer the sole effect of which is to provide reimbursement to employees for the purchase by such employees of health insurance coverage offered in the individual market (as defined in section 2791(e)(1)) of the Public Health Service Act), notwithstanding that the employer or an employee organization negotiates the cost or benefits of the arrangement.''.

(b) PHSA.—Section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)) is amended by adding at the end the following: ''Such term does not include an arrangement maintained by an employer the sole effect of which is to provide reimbursement to employees for the purchase by such employees of health insurance

coverage offered in the individual market, notwithstanding that the employer or an employee organization negotiates the cost or benefits of the arrangement.''.

(c) IRC.—Section 9832(a) of the Internal Revenue Code of 1986 (relating to definitions) is amended by inserting before the period the following: '', except that such term does not include an arrangement maintained by an employer the sole effect of which is to provide reimbursement to employees for the purchase by such employees of health insurance coverage offered in the individual market (as defined in section 2791(e)(1)) of the Public Health Service Act), notwithstanding that the employer or an employee organization negotiates the cost or benefits of the arrangement.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2007.

Subtitle B—Access to Health Care

SEC. 311. STATE HIGH RISK POOLS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, each State shall have established, and be operating, a qualified high risk pool (as defined for purposes of section 2745 of the Public Health Service Act (42 U.S.C. 300gg–45)) or a State-designated

alternative that ensures access to private health insurance for medically uninsurable individuals.

(b) BONUS FOR COMPLIANCE.—

(1) ONE-TIME PAYMENT.—If the Secretary of Health and Human Services determines that a State has satisfied the requirement of subsection (a) with respect to a fiscal year, the Secretary shall increase the total amount of Federal payments made to the State under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for the succeeding fiscal year by an amount equal to 1 percent of such payments (or, if such succeeding fiscal year is fiscal year 2010 or any fiscal year thereafter, by an amount equal to 1 percent of the State Medicaid assistance allotment determined for the State for such succeeding fiscal year under section 1939(b) of such Act). The additional amount paid to a State for a fiscal year pursuant to this paragraph shall be used for maintenance and operational costs of a qualified high risk pool (as so defined) or a State-designated alternative that ensures access to private health insurance for medically uninsurable individuals.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fis-

cal year such sums as may be necessary to carry out this subsection.

SEC. 312. FEDERALLY QUALIFIED HEALTH CENTERS.

(a) EVALUATION.—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, the Secretary of Health and Human Services shall evaluate the effect of federally qualified health centers on proximate rural hospitals.

(b) LIMITATION ON GRANTS.—Notwithstanding any other provision of law, if the Secretary of Health and Human Services determines, based on an evaluation conducted under subsection (a), that a federally qualified health center is having a detrimental effect on a private hospital facility, the Secretary may revoke a grant awarded by the Secretary to such health center or limit the scope of services of the health center under such a grant.

Subtitle C—Interstate Market for Health Insurance

SEC. 321. SHORT TITLE.

This subtitle may be cited as ''Health Care Choice Act of 2007''.

SEC. 322. SPECIFICATION OF CONSTITUTIONAL AUTHORITY FOR ENACTMENT OF LAW.

This subtitle is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

SEC. 323. FINDINGS.

Congress finds the following:

(1) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(2) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.

(3) In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the States in regulating this coverage.

(4) The establishment of risk-retention groups has provided a successful model for the sale of insurance across State lines, as the acts establishing those groups allow insurance to be sold in multiple States but regulated by a single State.

SEC. 324. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

"PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

"SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate 1 such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

''(2) SECONDARY STATE.—The term 'secondary State' means, with respect to individual health insur-

ance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

''(3) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

''(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

''(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

''(6) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that,

based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

"(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

"(B) to pay other obligations in the normal course of business.

"(7) COVERED LAWS.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

"(A) individual health insurance coverage issued by a health insurance issuer;

"(B) the offer, sale, and issuance of individual health insurance coverage to an individual; and

"(C) the provision to an individual in relation to individual health insurance coverage of—

"(i) health care and insurance related services;

"(ii) management, operations, and investment activities of a health insurance issuer; and

"(iii) loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

"(8) STATE.—The term 'State' means only the 50 States and the District of Columbia.

"(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

"(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

"(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

"(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

"(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

"(E) Refusing to pay claims without conducting a reasonable investigation.

"(F) Failing to affirm or deny coverage of claims within a reasonable period of time after

having completed an investigation related to those claims.

''(10) FRAUD AND ABUSE.—The term 'fraud and abuse' means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, 1 or more of the following:

''(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to 1 or more of the following:

''(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

''(ii) The rating of an insurance policy or reinsurance contract.

''(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

''(iv) Premiums paid on an insurance policy or reinsurance contract.

''(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

''(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

''(vii) The financial condition of an insurer or reinsurer.

''(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from 1 or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

''(ix) The issuance of written evidence of insurance.

''(x) The reinstatement of an insurance policy.

''(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

''(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of insurance.

''(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

''SEC. 2796. APPLICATION OF LAW.

''(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

''(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

"(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

"(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

"(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

"(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

"(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

"(ii) any such examination is conducted in accordance with the examiners'

handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

''(D) to comply with a lawful order issued—

''(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

''(ii) in a voluntary dissolution proceeding;

''(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

''(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

''(G) to comply with any State law regarding fraud and abuse (as defined in section

2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction; or

''(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9));

''(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

''(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

''(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of the primary State, and the name of the secondary State, respectively, for the coverage concerned:

'This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and

it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.'.

''(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

''(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

''(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

''(B) increase the premiums assessed the individual for such coverage based on a health-status related factor or change of a health-status related factor or the past or prospective claim experience of the insured individual.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

''(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

''(B) from raising premium rates for all policyholders within a class based on claims experience;

''(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

''(i) are disclosed to the consumer in the insurance contract;

''(ii) are based on specific wellness activities that are not applicable to all individuals; and

"(iii) are not obtainable by all individuals to whom coverage is offered;

"(D) from reinstating lapsed coverage; or

"(E) from retroactively adjusting the rates charged an individual insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

"(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

"(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

"(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

''(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

''(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

''(B) written notice of any change in its designation of its primary State; and

''(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

''(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

''(A) a member of the American Academy of Actuaries; or

''(B) a qualified loss reserve specialist.

''(h) POWER OF COURTS TO ENJOIN CONDUCT.—Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin—

''(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

''(2) the solicitation or sale of individual health insurance coverage by, or operation of, a health insurance issuer that is in hazardous financial condition.

''(i) STATE POWERS TO ENFORCE STATE LAWS.—

''(1) IN GENERAL.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

''(2) COURTS OF COMPETENT JURISDICTION.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

''(j) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

''(k) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

"SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

''A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the primary State does not meet the following requirements:

''(1) The State insurance commissioner must use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

''(2) The State must have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage unless the issuer provides an independent review mechanism functionally equivalent (as determined by the primary State insurance commissioner or official) to that prescribed in the

'Health Carrier External Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part.

"SEC. 2798. ENFORCEMENT.

"(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

"(b) SECONDARY STATE'S AUTHORITY.—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

"(c) COURT INTERPRETATION.—In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

"(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individual health insurance coverage offered, issued, or sold after the date of the enactment of this Act.

SEC. 325. SEVERABILITY.

If any provision of this subtitle or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this subtitle and the application of the provisions of such to any other person or circumstance shall not be affected.

TITLE IV—IMPROVEMENTS TO THE MEDICARE PROGRAM

Subtitle A—MediChoice for Seniors

SEC. 401. SETTING THE BENCHMARK EQUAL TO THE NATIONAL AVERAGE BID.

(a) SETTING BENCHMARK.—

(1) LOCAL PLANS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(A) in subsection (j)(1)(A)—

(i) by striking ''beginning with 2007'' and inserting ''for 2007 and 2008''; and

(ii) by inserting ''(or, beginning with 2009, an amount equal to the national average MA statutory non-drug monthly bid

amount computed under subsection (l))'' after ''for the area''; and

(iii) by inserting ''and adjusted as appropriate (for years beginning with 2009) using the geographic adjustment methodology established under subsection (m)'' before ''; or''; and

(B) by adding at the end the following new subsections:

''(l) COMPUTATION OF NATIONAL AVERAGE MA STATUTORY NON-DRUG MONTHLY BID AMOUNT.—

''(1) IN GENERAL.—For each year (beginning with 2009) the Secretary shall compute a national average MA statutory non-drug monthly bid amount equal to the average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E)) for each MA plan, including an MA regional plan.

''(2) WEIGHTED AVERAGE.—The national average MA statutory non-drug monthly bid amount computed under subparagraph (A) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

''(m) METHODOLOGY FOR GEOGRAPHICALLY ADJUSTING THE NATIONAL AVERAGE MA STATUTORY NON-DRUG MONTHLY BID AMOUNT.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall establish an appropriate methodology for adjusting the amount of the national average MA statutory non-drug monthly bid amount in a year to take into account, in a budget neutral manner, variations in input costs based on the provision of items and services in different geographic areas.

''(2) MAXIMIZE PLAN PARTICIPATION.—The Secretary shall establish the methodology under paragraph (1) in a manner that maximizes participation of plans in the program under this part.''.

(2) REGIONAL PLANS.—Section 1858(f)(1) of the Social Security Act (42 U.S.C. 1395w–27a(f)(1)) is amended to read as follows:

''(1) COMPUTATION FOR REGIONS.—For purposes of section 1853(j)(2) and this section, subject to subsection (e), the term 'MA region-specific non-drug monthly benchmark amount' means, with respect to an MA region for a month in a year—

"(A) for 2006, 2007, and 2008, the sum of the 2 components described in paragraph (2) for the region and year; and

"(B) for 2009 and each subsequent year, the national average MA statutory non-drug monthly bid amount computed under section 1853(l) as adjusted as appropriate using the geographic adjustment methodology established under section 1853(m).

The Secretary shall compute such benchmark amount for each MA region before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2006)".

(3) CONFORMING AMENDMENTS.—1853(b)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(b)(1)(B)) is amended—

(A) in clause (i)(I), by inserting "and the MA area-specific non-drug monthly benchmark amount under subsection (j), including the geographic adjusters under subsection (l) to be used in computing such amount, for each MA payment area for the year" before the period at the end; and

(B) in clause (ii), by inserting ", including the geographic adjusters under section 1853(l) to be used in computing such amount" before the period at the end.

(b) STUDY AND REPORT TO CONGRESS.—

(1) REVIEW.—Not less frequently that once every five years, the Secretary of Health and Human Services shall conduct a review that compares—

(A) the national average MA statutory non-drug monthly bid amount (as determined under subsection (l) of section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as added by subsection (a)); and

(B) the average per capita cost for the United States, as estimated by the Secretary under section 1876(a)(4) of such Act (42 U.S.C. 1395mm(a)(4)).

(2) REPORT TO CONGRESS.—The Secretary of Health and Human Services shall submit a report to Congress on each review conducted under paragraph (1).

SEC. 402. ENHANCEMENT OF BENEFICIARY REBATES.

Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended by insert-

ing ''(or 100 percent in the case of plan years beginning on or after January 1, 2009)'' after ''75 percent''.

SEC. 403. ALTERNATIVE BENEFIT DESIGN TO ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.

Part C of title XVIII of the Social Security Act is amended by adding at the end the following new section:

''ALTERNATIVE BENEFIT DESIGN TO ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS

''SEC. 1860C–2. (a) BENEFITS.—

''(1) IN GENERAL.—Notwithstanding the provisions of this part and subject to paragraph (2), beginning with 2009, under procedures established by the Secretary, a Medicare Advantage plan offered by a Medicare Advantage organization may provide different benefits than those required under section 1852(a) so long as the Secretary finds that the benefit design meets requirements under the Employee Retirement Income Security Act of 1974 or that the benefit design may be offered in any State under applicable State law.

''(2) REQUIREMENT.—A Medicare Advantage organization may not offer an alternative benefit design plan described in paragraph (1) for a year unless the organization also offers a Medicare Advantage plan that is not an alternative benefit design plan described in paragraph (1) for the year. Such

plan is not required to be offered in the same area as the alternative benefit design plan described in paragraph (1).

''(b) SPECIAL RULES.—The following rules shall apply to an alternative benefit design plan described in subsection (a)(1):

''(1) PAYMENT TO PLANS FOR NON-DRUG BENEFITS.—Payment to an organization for benefits under the plan (other than prescription drug benefits) shall be determined in the same manner as payments are determined under clauses (i) and (ii) of section 1853(a)(1)(B), except that in applying such clauses the monthly bid amount described in paragraph (2)(B)(i) of this subsection shall be substituted for the unadjusted MA statutory non-drug monthly bid amount.

''(2) SUBMISSION OF BIDS.—Notwithstanding paragraph (6) of section 1854(a), the information required to be submitted under such section is as follows:

''(A) The monthly aggregate bid amount for the provision of all items and services under the plan, which amount shall be based on average revenue requirements (as used for purposes of section 1302(8) of the Public Health Service

Act) in the payment area for an enrollee with a national average risk profile for the factors described in section 1853(a)(1)(C) (as specified by the Secretary).

''(B) The proportions of such bid amount that are attributable to—

''(i) the provision of items and services other than prescription drug coverage; and

''(ii) the provision of basic prescription drug coverage and supplemental prescription drug coverage.

''(C) The actuarial basis for determining the amount under subparagraph (A) and the proportions described in subparagraph (B) and such additional information as the Secretary may require to verify such actuarial bases and the projected number of enrollees in each MA local area.

''(D) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in section 1854(e)(4)(A).

''(E) With respect to qualified prescription drug coverage, the information required under section 1860D–4, as incorporated under section 1860D–11(b)(2), with respect to such coverage.

''(3) PREMIUM.—In determining the monthly amount (if any) of the premium charged to an individual enrolled in the plan—

''(A) section 1854(b) shall be applied by substituting the monthly bid amount described in paragraph (2)(B)(i) of this subsection for the unadjusted MA statutory non-drug monthly bid amount; and

''(B) subparagraphs (C) and (D) of paragraph (2) of such section shall not apply.

''(c) APPLICATION.—

''(1) NO AFFECT ON SPECIAL BENEFIT RULES FOR REGIONAL PLANS.—The provisions of this section shall not affect the special benefit rules for MA regional plans under section 1852(a)(6).

''(2) NO EFFECT ON PRESCRIPTION DRUG COVERAGE.—The provisions of this section shall not effect the provision of prescription drug coverage under this part.

''(3) BID NOT TAKEN INTO ACCOUNT WHEN DETERMINING THE NATIONAL AVERAGE MA STATUTORY

NON-DRUG MONTHLY BID AMOUNT.—The bid for an alternative benefit design plan described in subsection (a)(1) shall not be taken into account when computing the national average MA statutory non-drug monthly bid amount under section 1853(l).

''(d) WAIVER.—To facilitate the offering of alternative benefit design plans described in subsection (a)(1) under this part, the Secretary may waiver or modify requirements under this part.''.

SEC. 404. MEDICARE ADVANTAGE HSA PLANS.

(a) PROVIDING MEDICARE ADVANTAGE HSA PLANS AS A TYPE OF PLAN UNDER THE MEDICARE ADVANTAGE PROGRAM.—Section 1851(a)(2) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)) is amended by adding at the end the following new subparagraph:

''(D) COMBINATION OF HSA PLAN AND CONTRIBUTIONS TO HSA.—A Medicare Advantage HSA plan, as defined in section 1859(b)(7), and a contribution into a Medicare Advantage health savings account (HSA).''.

(b) DEFINITION OF MEDICARE ADVANTAGE HSA PLAN.—Section 1859(b) of the Social Security Act (42 U.S.C. 1395w–28(b)) is amended by adding at the end the following new paragraph:

''(7) MEDICARE ADVANTAGE HSA PLAN.—

"(A) IN GENERAL.—The term 'Medicare Advantage HSA plan' means a Medicare Advantage plan that—

"(i) is a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986, including the application of subparagraphs (C) and (D) of such section);

"(ii) has a service area of—

"(I) not less than an entire State or territory; or

"(II) in the case of the District of Columbia, not less than the District of Columbia and 1 contiguous State;

"(iii) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of the annual deductible (as determined under section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986);

"(iv) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable

under parts A and B, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

''(v) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (iii) in the year, for a level of reimbursement that is not less than—

''(I) 100 percent of such expenses, or

''(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less.''.

(c) SPECIAL RULES FOR HSA PLANS.—Part C of title XVIII of the Social Security Act is amended by inserting after section 1858 the following new section:

''SPECIAL RULES FOR MEDICARE ADVANTAGE HSA PLANS

''SEC. 1858A. (a) IN GENERAL.—Except for the modifications described in the succeeding provisions of this section, a Medicare Advantage HSA plan shall be treated

in the same manner as an MSA plan is treated under this title.

''(b) SPECIAL PAYMENT RULES.—

''(1) IN GENERAL.—Section 1853(e) shall be applied—

''(A) in the heading, by substituting 'HSA' for 'MSA';

''(B) in paragraph (1)—

''(i) by substituting 'HSA premium (as defined in section 1858A(b)(2))' for 'MSA premium (as defined in section 1854(b)(2)(C))'; and

''(ii) by substituting 'HSA' for 'MSA' each place it appears;

''(C) in paragraph (2)—

''(i) in the heading, by substituting 'HEALTH' for 'MEDICAL';

''(ii) in the matter preceding subparagraph (A), by substituting 'a Medicare Advantage HSA plan' for 'an MSA plan';

''(iii) in subparagraph (A), by substituting 'HSA (as defined in section 138(b) of the Internal Revenue Code of 1986)' for 'MSA (as defined in section

138(b)(2) of the Internal Revenue Code of 1986)'; and

''(iv) in subparagraph (B), by substituting 'HSA' for 'MSA' each place it appears; and

''(D) without regard to paragraph (3) (requiring a lump-sum deposit of a medical savings account contribution during the first month election is effective).

''(2) DEFINITION OF MEDICARE ADVANTAGE MONTHLY HSA PREMIUM.—The term 'Medicare Advantage monthly HSA premium' has the same meaning given the term 'Medicare Advantage monthly MSA premium' under section 1854(b)(2)(D).

''(c) TREATMENT OF MEDICARE ADVANTAGE HSA PLANS UNDER PART D.—Rules with respect to prescription drug coverage under part D for MSA plans shall not apply to a Medicare Advantage HSA plan. For purposes of part D, a Medicare Advantage HSA plan shall be treated in the same manner as a coordinated care plan (as described in section 1851(a)(2)(A)(i)) is treated under such part.''.

(d) TAX TREATMENT OF MEDICARE ADVANTAGE HSA PLANS.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139A the following new section:

"SEC. 139B. MEDICARE ADVANTAGE HSA.

"(a) EXCLUSION.—Gross income shall not include—

"(1) any payment to the Medicare Advantage HSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act,

"(2) any amount contributed to such Medicare Advantage HSA by or on behalf of the individual under section 223, including the individual's employer as described in section 106(d), and

"(3) an amount equal to any one-time qualified rollover from any of the individual's health savings accounts, health reimbursement accounts, flexible spending accounts, and medical savings accounts (including any Medicare Advantage MSA).

"(b) MEDICARE ADVANTAGE HSA.—For purposes of this section, the term 'Medicare Advantage HSA' means a health savings account (as defined in section 223(d))—

"(1) which is designated as a Medicare Advantage HSA,

''(2) with respect to which no contribution may be made other than—

''(A) a contribution described in subsection (a), or

''(B) a trustee-to-trustee transfer described in subsection (c)(4),

''(3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

''(4) which is established in connection with an HSA plan described in section 1859(b)(7) of the Social Security Act.

''(c) SPECIAL RULES FOR DISTRIBUTIONS.—

''(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.—In applying section 223 to a Medicare Advantage HSA, qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder.

''(2) PENALTY FOR DISTRIBUTIONS FROM MEDICARE ADVANTAGE HSA NOT USED FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM BALANCE NOT MAINTAINED.—

''(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there

is a payment or distribution from a Medicare Advantage HSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 50 percent of the excess (if any) of—

''(i) the amount of such payment or distribution, over

''(ii) the excess (if any) of—

''(I) the fair market value of the assets in such HSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over

''(II) an amount equal to 60 percent of the deductible under the Medicare Advantage HSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

Section 223(f)(4) shall not apply to any payment or distribution from a Medicare Advantage HSA.

''(B) EXCEPTIONS.—Subparagraph (A) shall not apply if the payment or distribution is made on or after the date the account holder—

''(i) becomes disabled within the meaning of section 72(m)(7), or

''(ii) dies.

''(C) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all Medicare Advantage HSAs of the account holder shall be treated as 1 account,

''(ii) all payments and distributions not used exclusively to pay the qualified medical expenses of the account holder during any taxable year shall be treated as 1 distribution, and

''(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Section 223(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a Medicare Advantage HSA to the Secretary of Health and Human Services of an erroneous contribution to such HSA and of the net income attributable to such contribution.

''(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 223(f)(2) and paragraph (2) of this subsection

shall not apply to any trustee-to-trustee transfer from a Medicare Advantage HSA of an account holder to another Medicare Advantage HSA of such account holder.

''(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section 223(f)(8)(A) to an account which was a Medicare Advantage HSA of a decedent, the rules of section 223(f) shall apply in lieu of the rules of subsection (c) of this section with respect to the spouse as the account holder of such Medicare Advantage HSA.

''(e) REPORTS.—In the case of a Medicare Advantage HSA, the report under section 223(h)—

''(1) shall include the fair market value of the assets in such Medicare Advantage HSA as of the close of each calendar year, and

''(2) shall be furnished to the account holder—

''(A) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

''(B) in such manner as the Secretary prescribes in such regulations.''.

(2) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of

such Code is amended by inserting after the item relating to section 139A the following new item:

"Sec. 139B. Medicare Advantage HSA.".

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2009.

SEC. 405. REVIEW OF ADJUSTMENT MECHANISM USED UNDER THE MEDICARE ADVANTAGE PROGRAM.

(a) REVIEW.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall conduct a review of the adjustment mechanism used to adjust payments to Medicare Advantage organizations under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)). The Secretary shall take into account the results of such review in making payments to Medicare Advantage organizations for plan years beginning on or after January 1, 2009.

(b) CONSULTATION.—In conducting the review under subsection (a), the Secretary of Health and Human Services shall consult with industry representatives and other individuals and organizations that the Secretary determines appropriate.

Subtitle B—Enhancements to the Medicare Fee-For-Service Program

SEC. 411. ELIMINATION OF ANNUAL INDEXING OF INCOME THRESHOLDS FOR REDUCED PART B PREMIUM SUBSIDIES.

Paragraph (5) of section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is repealed.

SEC. 412. AUTHORITY TO ADJUST AMOUNT OF MEDICARE PART B PREMIUM TO REWARD POSITIVE HEALTH BEHAVIOR.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(2), by striking ''and (i)'' and inserting ''(i), and (j)''; and

(2) by adding at the end the following new subsection:

''(j)(1) With respect to the monthly premium amount for months after December 2008, the Secretary may adjust (under procedures established by the Secretary) the amount of such premium for an individual based on whether or not the individual participates in certain healthy behaviors, such as weight management, exercise, nutrition counseling, refraining from tobacco use, designating a health home, and other behaviors determined appropriate by the Secretary.

''(2) In making the adjustments under paragraph (1) for a month, the Secretary shall ensure that the total amount of premiums to be paid under this part for the month is equal to the total amount of premiums that would have been paid under this part for the month if no such adjustments had been made, as estimated by the Secretary.''.

SEC. 413. RECAPTURE OF MEDICARE DSH FUNDS.

(a) IN GENERAL.—Section 1886(d)(5)(F)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(i)) is amended by inserting ''and before January 1, 2010,'' after ''May 1, 1986,''.

(b) SAVINGS TO PART A TRUST FUND.—The savings to the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) by reason of the amendment made by paragraph (1) shall be used to strengthen the financial solvency of such Trust Fund.

SEC. 414. PRICE TRANSPARENCY REQUIREMENTS FOR MEDICARE PROVIDERS.

(a) TRANSPARENCY.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

''PRICE TRANSPARENCY REQUIREMENTS

''SEC. 1898. (a) PRE-TREATMENT DISCLOSURE.—A provider of services (as defined in section 1861(u)) and

a supplier (as defined in section 1861(d)) shall provide to each individual (regardless of whether or not the individual is a beneficiary under this title) who is scheduled to receive a treatment (or to begin a course of treatment) that is not for an emergency medical condition the estimated price that the provider of services or supplier will charge for the treatment (or course of treatment). Such price shall be determined at the time of scheduling.

''(b) POST-TREATMENT DISCLOSURE.—A provider of services (as so defined) and a supplier (as so defined) shall include with any bill that includes the charges for a treatment with respect to an individual (regardless of whether or not the individual is a beneficiary under this title), an itemized list of component charges for such treatment, including charges for drugs and medical equipment involved, as determined at the time of billing. With respect to each item included on such list, the provider of services or supplier shall include the price charged for the item.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to providers of services and suppliers on and after January 1, 2009.

Subtitle C—Value-Based Purchasing

SEC. 421. REPEAL OF PHYSICIAN OWNERSHIP REFERRAL PROHIBITIONS BASED ON COMPENSATION ARRANGEMENTS.

(a) IN GENERAL.—Section 1877(a)(2) of the Social Security Act (42 U.S.C. 1395nn(a)(2)) is amended by striking ''is—'' and all that follows through ''equity,'' and inserting the following: ''is (except as provided in subsection (c)) an ownership or investment interest in the entity through equity,''.

(b) CONFORMING AMENDMENTS.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended as follows:

(1) In subsection (b)—

(A) in the heading, by striking ''TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS'' and inserting ''WHERE FINANCIAL RELATIONSHIP EXISTS''; and

(B) by redesignating paragraphs (4) and (5) as paragraphs (7) and (8).

(2) In subsection (c)—

(A) by amending the heading to read as follows: ''EXCEPTION FOR OWNERSHIP OR IN-

VESTMENT INTEREST IN PUBLICLY TRADED SECURITIES AND MUTUAL FUNDS''; and

(B) in the matter preceding paragraph (1), by striking ''subsection (a)(2)(A)'' and inserting ''subsection (a)(2)''.

(3) In subsection (d)—

(A) by striking the heading and the matter preceding paragraph (1);

(B) in paragraph (3), by striking ''paragraph (1)'' and inserting ''paragraph (4)''; and

(C) by redesignating paragraphs (1), (2), and (3) as paragraphs (4), (5), and (6), and by transferring and inserting such paragraphs after paragraph (3) of subsection (b).

(4) By striking subsection (e).

(5) In subsection (f)—

(A) in the matter preceding paragraph (1), by striking ''ownership, investment, and compensation'' and inserting ''ownership and investment''; and

(B) in paragraph (2)—

(i) by striking ''subsection (a)(2)(A)'' and all that follows through ''subsection (a)(2)(B)),'' and inserting ''subsection (a)(2)),''; and

(ii) in paragraph (2), by striking ''or who have such a compensation relationship with the entity''.

(6) In subsection (h)—

(A) by striking paragraphs (1), (2), and (3);

(B) in paragraph (4)(A)—

(i) by striking clauses (iv) and (vi);

(ii) in clause (iii), by adding ''and'' at the end;

(iii) by redesignating clause (v) as clause (iv); and

(iv) in clause (iv), as redesignated by clause (iii), by striking '', and'' and inserting a period;

(C) in paragraph (4)(B), by striking ''RULES.—'' and all that follows through ''(ii) FACULTY'' and inserting ''RULES FOR FACULTY''; and

(D) by adding at the end of paragraph (4) the following new subparagraph:

''(C) MEMBER OF A GROUP.—A physician is a 'member' of a group if the physician is an owner or a bona fide employee, or both, of the group.''.

SEC. 422. REVISION OF DESIGNATED HEALTH SERVICES SUBJECT TO OWNERSHIP REFERRAL PROHIBITION.

(a) IN GENERAL.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraphs (B) through (K) and inserting the following:

''(B) Parenteral and enteral nutrients, equipment, and supplies.

''(C) Radiology services, including magnetic resonance imaging, computerized tomography, and ultrasound services.

''(D) Outpatient physical or occupational therapy services.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395nn(b)(2)), in the matter preceding subparagraph (A), is amended by striking ''services'' and all that follows through ''supplies)—'' and inserting ''services—''.

(2) Section 1877(h)(5)(C) of the Social Security Act (42 U.S.C. 1395nn(h)(5)(C)) is amended—

(A) by striking '', a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy,'' and inserting ''and a request by a ra-

diologist for magnetic resonance imaging or for computerized tomography''; and

(B) by striking ''radiologist, or radiation oncologist'' and inserting ''or radiologist''.

SEC. 423. EXCEPTIONS TO OWNERSHIP REFERRAL PROHIBITIONS.

(a) REVISIONS TO EXCEPTION FOR IN-OFFICE ANCILLARY SERVICES.—

(1) REPEAL OF SITE-OF-SERVICE REQUIREMENT.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(A) in subsection (b)(2), by striking subparagraph (A) and inserting the following new subparagraph:

''(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are under the general supervision of the physician or of another physician in the group practice; and'', and

(B) in subsection (h), by adding at the end following new paragraph:

''(8) GENERAL SUPERVISION.—An individual is considered to be under the 'general supervision' of a

physician if the physician (or group practice of which the physician is a member) is legally responsible for the services performed by the individual and for ensuring that the individual meets licensure and certification requirements, if any, applicable under other provisions of law, regardless of whether or not the physician is physically present when the individual furnishes an item or service.''.

(2) CLARIFICATION OF TREATMENT OF PHYSICIAN OWNERS OF GROUP PRACTICE.—Section 1877(b)(2)(B) of the Social Security Act (42 U.S.C. 1395nn(b)(2)(B)) is amended by striking ''physician or such group practice'' and inserting ''physician, such group practice, or the physician owners of such group practice''.

(3) CONFORMING AMENDMENT.—The heading of section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395nn(b)(2)) is amended by striking ''IN-OFFICE ANCILLARY SERVICES'' and inserting ''ANCILLARY SERVICES FURNISHED PERSONALLY OR THROUGH GROUP PRACTICE''.

(b) CLARIFICATION OF EXCEPTION FOR SERVICES FURNISHED IN A RURAL AREA.—Paragraph (5)(A) of section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as transferred by section 421(b)(3)(C), is

amended by striking ''substantially all'' and inserting ''not less than 75 percent''.

(c) REVISION OF EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) of the Social Security Act (42 U.S.C. 1395nn(b)(3)) is amended—

(1) in the heading by inserting ''; MANAGED CARE ARRANGEMENTS'' after ''PREPAID PLANS'';

(2) in the matter preceding subparagraph (A), by striking ''organization—'' and inserting ''organization, directly or through contractual arrangements with other entities, to individuals enrolled with the organization—'';

(3) in subparagraph (A), by inserting ''or part C'' after ''section 1876'';

(4) in subparagraph (D), by striking ''or'' at the end;

(5) in subparagraph (E), by striking the period at the end and inserting ''or which provides or arranges for the provision of health care items or services pursuant to a written agreement between the organization and an individual or entity if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is ob-

ligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk, or''; and

(6) by adding at the end the following new subparagraph:

''(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)).''.

(d) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—

(1) IN GENERAL.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as amended by paragraphs (1)(B) and (3)(C) of section 421(b), is amended—

(A) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9); and

(B) by inserting after paragraph (3) the following new paragraph:

''(4) SHARED FACILITY SERVICES.—In the case of a designated health service consisting of a shared facility service of a shared facility—

''(A) that is furnished—

''(i) personally by the referring physician who is a shared facility physician or personally by an individual directly employed by or under the general supervision of such a physician;

''(ii) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services; and

''(iii) to a patient of a shared facility physician; and

''(B) that is billed by the referring physician or a group practice of which the physician is a member.''.

(2) DEFINITIONS.—Section 1877(h) of the Social Security Act (42 U.S.C. 1395nn(h)), as amended by section 421(b)(6), is amended by inserting before paragraph (4) the following new paragraph:

''(1) SHARED FACILITY RELATED DEFINITIONS.—

''(A) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health

service furnished by the facility to patients of shared facility physicians.

''(B) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

''(C) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician (or a group practice of which the physician is a member) who has a financial relationship under a shared facility arrangement with the facility.

''(D) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

''(i) which is only between physicians who are providing services (unrelated to shared facility services) in the same building;

''(ii) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the

physicians in the arrangement, among the physicians in the arrangement; and

"(iii) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.".

(e) NEW EXCEPTION FOR SERVICES FURNISHED IN COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as amended by paragraphs (1)(B) and (3)(C) of section 421(b) and subsection (d)(1), is amended—

(1) by redesignating paragraphs (5) through (9) as paragraphs (6) through (10); and

(2) by inserting after paragraph (4) the following new paragraph:

"(5) NO ALTERNATIVE PROVIDERS IN AREA.—In the case of a designated health service furnished in any area with respect to which the Secretary determines that individuals residing in the area do not have reasonable access to such a designated health service for which subsection (a)(1) does not apply.".

(f) NEW EXCEPTION FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as amended by paragraphs (1)(B) and (3)(C) of section 421(b), subsection (d)(1), and subsection (e)(1), is amended—

(1) by redesignating paragraphs (6) through (10) as paragraphs (7) through (11); and

(2) by inserting after paragraph (5) the following new paragraph:

''(6) SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—In the case of a designated health service furnished in an ambulatory surgical center described in section 1832(a)(2)(F)(i).''.

(g) NEW EXCEPTION FOR SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as amended by paragraphs (1)(B) and (3)(C) of section 421(b), subsection (d)(1), subsection (e)(1), and subsection (f), is amended—

(1) by redesignating paragraphs (7) through (11) as paragraphs (8) through (12); and

(2) by inserting after paragraph (6) the following new paragraph:

''(7) SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—In the case of a designated health service furnished in a renal dialysis facility under section 1881.''.

(h) NEW EXCEPTION FOR SERVICES FURNISHED IN A HOSPICE.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as amended by paragraphs (1)(B)

and (3)(C) of section 421(b), subsection (d)(1), subsection (e)(1), subsection (f), and subsection (g), is amended—

(1) by redesignating paragraphs (8) through (12) as paragraphs (9) through (13); and

(2) by inserting after paragraph (7) the following new paragraph:

"(8) SERVICES FURNISHED BY A HOSPICE PROGRAM.—In the case of a designated health service furnished by a hospice program (as defined in section 1861(dd)(2)).".

(i) NEW EXCEPTION FOR SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as amended by paragraphs (1)(B) and (3)(C) of section 421(b), subsection (d)(1), subsection (e)(1), subsection (f), subsection (g), and subsection (h), is amended—

(1) by redesignating paragraphs (9) through (13) as paragraphs (10) through (14); and

(2) by inserting after paragraph (8) the following new paragraph:

"(9) SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—In the case of a designated health service furnished in

a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)).''.

(j) DEFINITION OF REFERRAL.—Section 1877(h)(5)(A) of the Social Security Act (42 U.S.C. 1395nn(h)(5)(A)) is amended—

(1) by striking ''an item or service'' and inserting ''a designated health service''; and

(2) by striking ''the item or service'' and inserting ''the designated health service''.

(k) CONFORMING AMENDMENT.—Section 1877(g)(6)(B) of the Social Security Act (42 U.S.C. 1395nn(g)(6)(B)) is amended by striking ''subsection (b)(4)'' and inserting ''subsection (b)(13)''.

(l) TRANSPARENCY.—The Secretary of Health and Human Services shall establish procedures for requiring a physician making a referral to an entity that would have been prohibited under section 1877 of the Social Security Act (42 U.S.C. 1395nn) if the amendments made by this section had not been made to disclose to the individual being referred the financial relationship that the physician has with the entity.

SEC. 424. EFFECTIVE DATE.

The amendments made by this subtitle shall apply to referrals made on or after the date of the enactment of

this Act, regardless of whether or not regulations are promulgated to carry out such amendments.

Subtitle D—Securing Medicare's Future for Tomorrow's Seniors

SEC. 431. MEDICAL RETIREMENT ACCOUNTS.

(a) IN GENERAL.—Title II of the Social Security Act (42 U.S.C. 401 et seq.) is amended—

(1) by inserting before section 201 the following:

"PART A—INSURANCE BENEFITS";

and

(2) by adding at the end the following:

"PART B—MEDICAL RETIREMENT ACCOUNTS

"SEC. 251. MEDICAL RETIREMENT ACCOUNT FUND.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There shall be established and maintained in the Treasury of the United States a Medical Retirement Account Fund in the same manner as the Thrift Savings Fund under section 8437 of title 5, United States Code (excluding paragraphs (4) and (5) of subsection (c) thereof).

''(2) CONTENTS OF FUND.—There is hereby appropriated to the Medical Retirement Account Fund amounts equivalent to—

''(A) the contributions received in the Treasury under sections 3101(b), 3111(b), and 1401(b) of the Internal Revenue Code of 1986 with respect to each eligible individual on and after the date of an election under section 252(a)(2), and

''(B) the aggregate of the contributions described in subparagraphs (B)(, (C), and (D) of section 252(c)(1) with respect to such eligible individuals.

''(b) INVESTMENT OF MEDICAL RETIREMENT ACCOUNT FUND.—Amounts in the Medical Retirement Account Fund shall be invested in the same manner as amounts in the Thrift Savings Fund are invested under section 8438 of title 5, United States Code.

''(c) ACCOUNTING AND INFORMATION.—The Executive Director of the Medical Retirement Account Board shall maintain accounts and provide information in the same manner as the Executive Director of the Thrift Savings Fund is required to maintain accounts and provide information with respect to the Thrift Savings Fund under section 8439 of title 5, United States Code.

''SEC. 252. MEDICAL RETIREMENT ACCOUNTS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—Within 30 days after receiving the first contribution under subsection (c) with respect to an eligible individual, the Medical Retirement Account Board shall establish a Medical Retirement Account for such individual in the Medical Retirement Account Fund. Each account shall be identified to the account holder by means of the account holder's social security account number.

''(2) ELIGIBLE INDIVIDUAL.—For purposes of this part, the term 'eligible individual' means any individual who, under regulations prescribed by the Secretary of Health and Human Services, makes an irrevocable election on or after the effective date of this part to renounce eligibility under the Medicare Program under title XVIII and establish a Medical Retirement Account.

''(b) TREATMENT OF ACCOUNT.—Except as provided in this section, a Medical Retirement Account shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a health savings account under section 223 of such Code (determined without regard to subsections (d)(1)(A)((ii) and (d)(2)(B) thereof).

''(c) CONTRIBUTIONS.—

"(1) IN GENERAL.—The Medical Retirement Account Board shall credit to the Medical Retirement Account of an eligible individual—

"(A) except as provided in paragraph (2), an amount equal to the sum of any amounts transferred to the Medical Retirement Account Fund under section 251(a)(2)(A) which are attributable to the contributions paid by or on behalf of such individual under sections 3101(b), 3111(b), and 1401(b) of the Internal Revenue Code of 1986, plus

"(B) at the time of such individual's retirement date determined under subsection (d)(1), an amount equal to the sum of any amounts transferred to the Federal Hospital Insurance Trust Fund under section 1817 which is attributable to such contributions paid on average by or on behalf of individuals in the same age cohort as such eligible individual under sections 3101(b), 3111(b), and 1401(b) of the Internal Revenue Code of 1986 (including any Trust Fund earnings on such amount), plus

"(C) any amount contributed to such Medical Retirement Account by the eligible individual or the eligible individual's employer, in-

cluding, in the case of an eligible individual who is a State government employee, any contribution under an applicable State law, to the extent the aggregate amount of contributions under this subparagraph for any calendar year does not exceed $10,000, adjusted for inflation in the same manner as the applicable dollar amount under section 402(g)(1)(B) of the Internal Revenue Code of 1986, and reduced in the same manner as under section 408A(c)(3) of such Code, plus

''(D) an amount equal to any one-time qualified rollover at the time of such individual's retirement from any of the eligible individual's health savings accounts, health reimbursement accounts, flexible spending accounts, and medical savings accounts.

''(2) REDISTRIBUTION.—Not later than 90 days after the end of each taxable year, the Secretary shall transfer such portion of the contributions paid under section 3111(b) or 1401(b) of the Internal Revenue Code of 1986 by or on behalf of eligible individuals whose wages or net earnings from self-employment exceed the contribution and benefit base under section 230 for such taxable year to Medical

Retirement Accounts of eligible individuals whose wages and net earnings from self-employment do not exceed such base for such taxable year in an amount per each Medical Retirement Account so as not to exceed 2.9 percent of the national average salary for each such Account.

''(d) DISTRIBUTIONS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), distributions may only be made from a Medical Retirement Account of an eligible individual on and after the date the eligible individual attains—

''(A) retirement age (as determined under section 216), or

''(B) if elected by such individual, early retirement age, but only if such individual presents proof of the purchase of a lifetime catastrophic health insurance policy upon such election.

''(2) DISTRIBUTION IN THE EVENT OF DEATH BEFORE THE DATE OF INITIAL DISTRIBUTION.—If the eligible individual dies before the date determined under paragraph (1), the balance in such individual's Medical Retirement Account shall be dis-

tributed in a lump sum, under rules established by the Medical Retirement Account Board—

"(A) to the Medical Retirement Account of a surviving spouse of such individual, and

"(B) in the case there is no surviving spouse or such spouse waives the right to such funds, to the Medical Retirement Accounts of the eligible individual's heirs.

"(3) DIVORCE.—The Medical Retirement Account Board shall issue regulations which provide that, in the case of an eligible individual with a Medical Retirement Account who becomes divorced after at least 10 years of marriage to the same spouse, contributions to the Account during the marriage and earnings on the Account during the marriage shall be divided evenly between the Account of such individual and a Medical Retirement Account of such individual's former spouse.

"SEC. 253. MEDICAL RETIREMENT ACCOUNT BOARD.

"(a) IN GENERAL.—There shall be established and maintained in the Social Security Administration a Medical Retirement Account Board in the same manner as the Federal Retirement Thrift Investment Board under subchapter VII of chapter 84 of title 5, United States Code.

''(b) EXECUTIVE DIRECTOR.—The Medical Retirement Account Board shall appoint an Executive Director in the same manner and with the same functions as the Executive Director of the Thrift Savings Board under section 8474 of title 5, United States Code.''.

(b) TAX TREATMENT OF CERTAIN CONTRIBUTIONS TO MEDICAL RETIREMENT ACCOUNTS.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after section 139B the following new section:

''SEC. 139C. MEDICAL RETIREMENT ACCOUNT CONTRIBUTIONS.

''Gross income shall not include any contribution to a Medical Retirement Account specified under section 252(c) of the Social Security Act or any earnings on such contributions.''.

(2) CLERICAL AMENDMENT.—The table of section for part III of subchapter B of chapter 1 of such Code, as amended by this Act, is amended by inserting after the item relating to section 139B the following new item:

''Sec. 139C. Medical Retirement Account contributions.''.

(c) CONFORMING AMENDMENTS TO THE MEDICARE PROGRAM.—

(1) PART A ENTITLEMENT.—Section 1811 of the Social Security Act (42 U.S.C. 1395d) is amended by adding at the end the following new sentence: ''On and after the effective date of part B of title II, the entitlement under the preceding sentence shall only apply to an individual who is not an eligible individual (as defined in section 252(a)(2)).''.

(2) PART A TRUST FUND.—The third sentence of section 1817 of the Social Security Act (42 U.S.C. 1395i) is amended in each of paragraphs (1) and (2) by inserting ''subject to section 251(a)(2)(A),'' before ''the taxes imposed''.

(3) PART B ELIGIBILITY.—Section 1836 of the Social Security Act (42 U.S.C. 1395o) is amended by adding at the end the following new sentence: ''On and after the effective date of part B of title II, the eligibility under the preceding sentence shall only apply to an individual who is not an eligible individual (as defined in section 252(a)(2)).''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on January 1, 2009.

(2) INTERNAL REVENUE CODE.—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2008.

TITLE V—KEEPING MEDICAID ON MISSION

SEC. 501. RESTRUCTURING OF MEDICAID FUNDING.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1939 as section 1940; and

(2) by inserting after section 1938, the following:

''MEDICAID MODERNIZED AND ON MISSION

''SEC. 1939. (a) STATE MEDICAID ASSISTANCE ALLOTMENTS.—Notwithstanding any other provision of this title, beginning with fiscal year 2010, and for each fiscal year thereafter—

''(1) no State shall receive a payment under section 1903(a); and

''(2) only in the case of a State with a State plan under this title that satisfies the conditions described in subsection (c), the Secretary shall pay such State the State Medicaid assistance allotment for the State determined under subsection (b).

''(b) DETERMINATION OF AMOUNT OF ALLOTMENTS.—

''(1) IN GENERAL.—Subject to paragraphs (4) and (5), the State Medicaid assistance allotment payable to a State (other than a State referred to in subparagraph (B)(ii)) for a fiscal year shall be the amount that bears the same ratio to the amount appropriated under subsection (f) for the fiscal year (reduced by the amount of the allotments made under paragraph (2)), as the ratio of—

''(A) the sum of—

''(i) the population of the State;

''(ii) the number of individuals residing in the State whose family income does not exceed the poverty line (as defined in section 2110(c)(5) applicable to a family of the size involved);

''(iii) the number of individuals residing in the State who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)); and

''(iv) the number of disabled individuals residing in the State; to

''(B) the sum of the amounts determined under subparagraph (A).

''(2) ALLOTMENTS TO TERRITORIES.—

"(A) IN GENERAL.—Subject to paragraphs (4) and (5), the State Medicaid assistance allotment payable to a commonwealth or territory referred to in subparagraph (B) for a fiscal year shall be the amount that bears the same ratio to 0.25 percent of the amount appropriated under subsection (f) for the fiscal year, as the percentage specified in subparagraph (B)) for the commonwealth or territory bears to the sum of such percentages for all such commonwealths and territories so described.

"(B) PERCENTAGE.—The percentage specified in this subparagraph for—

"(i) Puerto Rico is 91.6 percent,

"(ii) Guam is 3.5 percent,

"(iii) the Virgin Islands is 2.6 percent,

"(iv) American Samoa is 1.2 percent, and

"(v) the Northern Mariana Islands is 1.1 percent.

"(3) DETERMINATION OF POPULATION AND NUMBER OF INDIVIDUALS.—The Secretary shall determine the State populations and numbers of individuals described in paragraph (1) on the basis of

the most recent American Community Survey of the Bureau of the Census (or, until such data is available, on the basis of the 3 most recent Annual Social and Economic Supplements of the Current Population Survey of the Bureau of the Census) and such other data as the Secretary determines is necessary.

''(4) PHASE-IN; TRANSITION ASSISTANCE.—

''(A) PHASED-IN CHANGE IN FUNDING AMOUNTS.—Notwithstanding paragraph (1) and (2), subject to subparagraph (B), the State Medicaid assistance allotment determined for a State for each of fiscal years 2010 through 2013 shall be the amount equal to the following:

''(i) FISCAL YEAR 2010.—In the case of fiscal year 2010, the amount equal to the sum of—

''(I) 80 percent of the amount paid to the State under section 1903(a) for fiscal year 2006; and

''(II) 20 percent of the amount of the State Medicaid assistance allotment that would be paid to the State under paragraph (1) or (2) (as appli-

cable) without regard to this paragraph.

"(ii) FISCAL YEAR 2011.—In the case of fiscal year 2011, the amount equal to the sum of—

"(I) 60 percent of the amount paid to the State under section 1903(a) for fiscal year 2006; and

"(II) 40 percent of the amount of the State Medicaid assistance allotment that would be paid to the State under paragraph (1) or (2) (as applicable) without regard to this paragraph.

"(iii) FISCAL YEAR 2012.—In the case of fiscal year 2012, the amount equal to the sum of—

"(I) 40 percent of the amount paid to the State under section 1903(a) for fiscal year 2006; and

"(II) 60 percent of the amount of the State Medicaid assistance allotment that would be paid to the State under paragraph (1) or (2) (as appli-

cable) without regard to this paragraph.

''(iv) FISCAL YEAR 2013.—In the case of fiscal year 2013, the amount equal to the sum of—

''(I) 20 percent of the amount paid to the State under section 1903(a) for fiscal year 2006; and

''(II) 80 percent of the amount of the State Medicaid assistance allotment that would be paid to the State under paragraph (1) or (2) (as applicable) without regard to this paragraph.

''(B) TRANSITION ASSISTANCE.—The State Medicaid assistance allotment paid to a State for any of fiscal years 2010 through 2014 shall not be less than the approximate total amount paid to the State under section 1903(a) for fiscal year 2006.

''(c) CONDITIONS DESCRIBED.—For purposes of subsection (a), the conditions described in this subsection are the following:

''(1) POPULATIONS COVERED.—

"(A) IN GENERAL.—Subject to subparagraph (B), the State uses its State Medicaid assistance allotment to provide medical assistance (subject, notwithstanding section 1916 or 1916A, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine) only for populations of individuals—

"(i) who are eligible for medical assistance under the State plan on January 1, 2008; or

"(ii) whose family income does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)).

"(B) PRIORITY FOR MANDATORY POPULATIONS.—In determining the populations eligible for medical assistance under the State plan in accordance with subparagraph (A), the State shall give priority to making populations described in section 1902(a)(10)(A)(i) eligible for such assistance.

"(C) OPTION TO RISK-ADJUST PREMIUMS.—With respect to populations covered in accordance with this paragraph, a State may

impose risk-adjusted premiums based on chronic disease conditions.

''(2) BENEFITS.—

''(A) IN GENERAL.—The State does not provide medical assistance for purposes of any item or service that is not described in section 1905(a) as in effect on January 1, 2008 or authorized to be provided by any State under a waiver approved under section 1115, 1915, or otherwise, as in effect on January 1, 2008.

''(B) HEALTH PROMOTION AND DISEASE PREVENTION.—At State option, the State implements initiatives designed to educate the population of the State with respect to health promotion and disease prevention of the top 3 lethal diseases for the State.

''(3) MATCHING REQUIREMENT.—The State provides non-Federal matching funds of not less than $1 for every $3 of Federal funds received under this section.

''(4) LIMITATION ON ADMINISTRATIVE EXPENDITURES.—The total amount of reasonable costs incurred by the State to administer the State plan for a fiscal year shall not exceed the amount equal to 3 percent of the State Medicaid assistance allotment

paid to the State under this section for such fiscal year.

''(5) APPLICATION OF RESTRICTIONS ON USE OF FUNDS.—The restrictions on the use of Federal funds appropriated to carry out this title contained in title V of division F of the Consolidated Appropriations Act, 2005, shall apply to the State Medicaid assistance allotments paid to States under this section for fiscal year 2010 and each fiscal year thereafter in the same manner as such restrictions apply to amounts appropriated under division F of such Act.

''(6) PROMOTION OF PRICE AND QUALITY TRANSPARENCY IN THE PRIVATE MARKET.—The State provides an assurance that the State has implemented initiatives—

''(A) to promote price and quality transparency with respect to each type of health insurance offered by health insurance issuers in the State; and

''(B) to ensure that any provider of a health care item or service that is paid for (in whole or in part) with Federal or State funds publishes price information with respect to such

item or service and makes the information readily available to consumers.

''(7) ANNUAL REPORT ON HEALTH COVERAGE.—The State submits annual reports to the Secretary that—

''(A) describe the State's expenditure of the State Medicaid assistance allotment;

''(B) include—

''(i) the number of individuals provided medical assistance through such allotment;

''(ii) the average per beneficiary spending of the allotment with respect to—

''(I) acute care; and

''(II) long-term care; and

''(C) the number of individuals in the State who are enrolled in private health coverage.

''(d) OPTION TO SUBSIDIZE PURCHASE OF PRIVATE MARKET COVERAGE.—

''(1) IN GENERAL.—Subject to paragraph (4), a State may elect to permit individuals eligible for medical assistance in accordance with subsection (c)(1) to opt-out of enrollment under the State plan (on a risk-adjusted basis) in return for payment on

the individual's behalf of the individual health insurance purchase subsidy amount determined under paragraph (2) to an issuer of health insurance coverage within the private market.

''(2) INDIVIDUAL HEALTH INSURANCE PURCHASE SUBSIDY.—For purposes of paragraph (1), the individual health insurance purchase subsidy amount determined under this paragraph is equal to the actuarial average cost of providing coverage under the State plan under this title to all enrollees in such plan.

''(3) AUTHORITY TO COMBINE SUBSIDY WITH REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE.—Payment of an individual health insurance purchase subsidy on behalf of an individual under this subsection shall not be taken into account for purposes of determining the amount the individual is allowed as a credit under section 36 of the Internal Revenue Code of 1986 for qualified health insurance.

''(4) ENROLLMENT INFORMATION AND ASSISTANCE.—A State may only make the election described in paragraph (1) if the State—

''(A) makes available to the individuals described in paragraph (1) benefit enrollment

counselors to assist the individuals with selecting coverage within the individual market; and

''(B) has implemented procedures to ensure that accurate and complete plan information is provided to such individuals prior to their enrollment in a plan within such market.

''(5) FACILITATION OF USE OF FEDERAL TAX CREDIT TO ELECT CATASTROPHIC OR OTHER PRIVATE MARKET COVERAGE.—A State may establish mechanisms to facilitate the enrollment of individuals who elect to opt-out of the State plan in private health insurance or in qualified health insurance for purposes of such individuals being allowed a credit under section 36 of the Internal Revenue Code of 1986.

''(e) AVAILABILITY.—Amounts paid to a State under this section shall remain available for expenditure without fiscal year limitation.

''(f) APPROPRIATIONS.—

''(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for making State Medicaid assistance allotments to States under this section—

''(A) for fiscal year 2010, $212,000,000,000; and

''(B) for each of fiscal years 2011 through 2017, the amount appropriated under this subsection for the preceding fiscal year, increased by the percentage increase (if any) in the chain-weighted consumer price index for all urban consumers (all items; United States city average) for the previous fiscal year.

''(2) ADDITIONAL APPROPRIATION FOR TRANSITION YEARS; HOLD HARMLESS.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for the period of fiscal years 2010 through 2014, $20,000,000,000, for purposes of carrying out subsection (b)(4)(B).''.

SEC. 502. MEDICAID ADVANTAGE PROGRAM.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 501, is amended by—

(1) redesignating section 1940 as section 1941; and

(2) inserting after section 1939 the following new section:

''MEDICAID ADVANTAGE PROGRAM

''SEC. 1940. (a) DEFINITIONS.—In this section:

''(1) MEDICAID ADVANTAGE ELIGIBLE INDIVIDUAL.—The term 'Medicaid Advantage eligible individual' means an individual who—

''(A) is a full-benefit dual eligible individual (as defined in section 1935(c)(6)); and

''(B) resides in a participating State.

''(2) PARTICIPATING STATE.—The term 'participating State' means a State that elects to offer a State Medicaid Advantage program under this section.

''(3) PROGRAM.—The term 'program' means a State Medicaid Advantage program.

''(4) STATE MEDICAID ADVANTAGE PROGRAM.—The term 'State Medicaid Advantage program' means a program offered by a State that provides individuals enrolled in the program a medical home where they receive a seamless continuum of medical care and care management that meets the following requirements:

''(A) OPERATION.—The primary manager of the program is the State.

''(B) INTEGRATED COVERAGE.—The program provides integrated health care benefits to Medicaid Advantage eligible individuals.

''(b) ESTABLISHMENT.—

''(1) IN GENERAL.—Beginning with fiscal year 2010, a State may elect to provide benefits to Medicaid Advantage eligible individuals who elect to enroll in a program established under this section. Such benefits shall be provided instead of benefits under title XVIII or under a State plan under this title.

''(2) ENROLLMENT.—

''(A) IN GENERAL.—A participating State shall establish procedures to enroll Medicaid Advantage eligible individuals in the program. Such procedures shall ensure that a Medicaid Advantage eligible individual may elect to not enroll and to disenroll upon request from the program.

''(B) PRESERVATION OF ORIGINAL MEDICARE AND MEDICAID BENEFITS.—Nothing in this section shall be construed to limit the right of a Medicaid Advantage eligible individual who is entitled to benefits under title XVIII or under a State plan under this title to receive such benefits if the individual elects to not enroll or to disenroll from the program.

''(3) PAYMENTS.—

''(A) IN GENERAL.—The Secretary shall develop a system for making risk-adjusted payments on a capitated basis to participating States for the cost of providing items and services to each individual enrolled in the program that would, but for the application of this section, be covered under—

''(i) title XVIII, including the cost of providing qualified prescription drug coverage under part D of such title; or

''(ii) a State plan under this title.

''(B) DETERMINATION OF PAYMENT AMOUNT.—The Secretary shall use actuarial data and payment history in determining the payment amount under such system with respect to each individual enrolled in the program, and shall adjust the payment amount to take into account the comparative frailty of such individuals and such other factors as the Secretary determines to be appropriate.

''(C) UPDATE OF PAYMENT SYSTEM.—The Secretary shall update the payment system developed under this paragraph as appropriate.

''(D) STATE PROCEDURES.—A participating State shall establish such procedures for

the submission of claims and the transmission of data as the Secretary determines appropriate in order to carry out the payment system developed under this paragraph.

''(4) SCOPE OF BENEFITS.—A participating State shall provide individuals enrolled in the program, regardless of the source of payment and directly or under contracts with other entities, at a minimum—

''(A) all items and services covered under title XVIII and all items and services covered under this title, except that States shall have authority and flexibility to design benefit packages that meet the specific needs of Medicaid Advantage eligible individuals, including the needs of such individuals with mental illness;

''(B) qualified prescription drug coverage (as defined in section 1860D–2(a)(1)); and

''(C) such other items and services as the State determines appropriate.

''(c) RESPONSIBILITIES OF PARTICIPATING STATES.—

''(1) BIDDING PROCESS FOR HEALTH PLANS.—

''(A) IN GENERAL.—A participating State shall establish procedures for health plans to

participate in a bidding process to enter into a contract under paragraph (2) to provide services to Medicaid Advantage eligible individuals under the program.

''(B) BID SUBMISSION.—Each health plan participating in the bidding process established under paragraph (1) shall submit a bid representing the estimated cost to such plans of providing Medicaid Advantage eligible individuals the benefits described in subsection (b)(4).

''(2) CONTRACTS WITH HEALTH PLANS.—

''(A) IN GENERAL.—A participating State shall enter into contracts with health plans, including managed care health plans, in order to provide integrated health care benefits to Medicaid Advantage eligible individuals enrolled in the program.

''(B) RESPONSIBILITY FOR PROVIDING CARE.—Each contract entered into under this paragraph shall provide that the health plan is responsible for—

''(i) providing the benefits described in subsection (b)(4) to individuals enrolled in the program;

''(ii) collecting performance data on treatments and outcomes for each such individual; and

''(iii) providing such data to the State for use in monitoring the program under this section.

''(C) ENSURING QUALITY AND VALUE.—

''(i) PROMOTING COMPETITION.—A participating State shall provide incentives for health plans to compete with respect to the quality and value of the services provided to Medicaid Advantage eligible individuals who are enrolled in the program.

''(ii) REWARDING EFFICIENCY.—A participating State may reward health plans that provide higher quality care at a reduced price under the program.

''(3) CHOICE OF PLANS.—A participating State shall establish procedures to allow Medicaid Advantage eligible individuals to choose from among the competing plans that the State enters into a contract with under paragraph (2).

''(4) PAYMENT PROCEDURES.—A participating State shall establish procedures with respect to payments in accordance with subsection (b)(3)(D).

''(5) MONITORING AND ENFORCEMENT.—A participating State shall share responsibility with the Secretary for—

''(A) carefully monitoring health plans that the State enters into a contract with under paragraph (2); and

''(B) bringing action against those health plans that do not meet their obligations under such contracts.

''(d) FEDERAL RESPONSIBILITIES.—

''(1) PAYMENTS TO PARTICIPATING STATES.—The Secretary shall provide for payments to participating States in accordance with subsection (b)(3).

''(2) MONITORING AND ENFORCEMENT.—

''(A) GOALS.—The Secretary shall set and monitor goals for programs.

''(B) MONITORING AND ENFORCEMENT.—The Secretary shall share responsibility with a participating State for—

''(i) carefully monitoring health plans that the State enters into a contract with under subsection (c)(2); and

''(ii) bringing appropriate action against those health plans that do not

meet their obligations under such contracts.

''(3) ACCESS TO PRESCRIPTION DRUG DATA.—

''(A) IN GENERAL.—Notwithstanding any provision of law, the Secretary shall ensure that States have access to prescription drug data submitted by prescription drug plans and MA–PD plans under part D of title XVIII for the purpose of carrying out the program under this section.

''(B) SAFEGUARDS.—The Secretary shall ensure that States have in place appropriate safeguards to protect against the unauthorized disclosure of data provided under subparagraph (A).

''(e) WAIVERS OF REQUIREMENTS .—With respect to carrying out a State Medicaid Advantage program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

''(1) Section 1902(a)(1), relating to any requirement that a program or benefits under such a program be provided in all areas of a State.

''(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

''(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a program.

''(4) Section 1903(m)(2)(A), insofar as it restricts a program from receiving prepaid capitation payments.

''(5) Such other provisions of this title that the Secretary determines are inapplicable to carrying out a program under this section.''.

SEC. 503. HIGH PERFORMANCE BONUSES.

Section 1939 of the Social Security Act, as added by section 501, is amended by adding at the end the following:

''(g) BONUS TO REWARD HIGH PERFORMANCE STATES.—

''(1) IN GENERAL.—In addition to the State Medicaid assistance allotments paid to States in accordance with the preceding provisions of this section, the Secretary shall make a payment pursuant to this subsection to each State for each bonus year for which the State is a high performing State.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the

amount of the payment under this subsection to a high performing State for a bonus year.

''(B) LIMITATION.—The amount payable to a State under this subsection for a bonus year shall not exceed 5 percent of the State Medicaid assistance allotment paid to the State under subsection (a).

''(3) USE OF FUNDS.—Amounts paid to a State under this subsection shall be used to facilitate the enrollment of uninsured individuals who reside in the State in private health insurance or to maintain the enrollment of individuals in such health insurance.

''(4) DEFINITIONS.—As used in this paragraph:

''(A) BONUS YEAR.—The term 'bonus year' means each of fiscal years 2010 through 2017.

''(B) HIGH PERFORMING STATE.—The term 'high performing State' means, with respect to a bonus year, a State that—

''(i) with respect to, each of bonus years 2010 and 2011, the Secretary determines that at least 90 percent of the total population of the State is enrolled in private health insurance coverage; and

''(ii) with respect to each of bonus years 2012 through 2017, the Secretary determines that—

''(I) at least 95 percent of the total population of the State is enrolled in private health insurance coverage; and

''(II) the State has satisfies the conditions in subsection (c).

''(5) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for the period of fiscal years 2010 through 2017, $5,000,000,000 for making payments under this subsection.''.

TITLE VI—ADMINISTRATIVE HEALTH CARE TRIBUNALS

SEC. 601. STATE GRANTS TO CREATE ADMINISTRATIVE HEALTH CARE TRIBUNALS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

''SEC. 399R. STATE GRANTS TO CREATE ADMINISTRATIVE HEALTH CARE TRIBUNALS.

''(a) IN GENERAL.—The Secretary may award grants to States for the development, implementation, and eval-

uation of administrative health care tribunals that comply with this section, for the resolution of disputes concerning injuries allegedly caused by health care providers.

''(b) CONDITIONS FOR DEMONSTRATION GRANTS.—To be eligible to receive a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as may be required by the Secretary. A grant shall be awarded under this section on such terms and conditions as the Secretary determines appropriate.

''(c) REPRESENTATION BY COUNSEL.—A State that receives a grant under this section may not preclude any party to a dispute before an administrative health care tribunal operated under such grant from obtaining legal representation during any review by the expert panel under subsection (d), the administrative health care tribunal under subsection (e), or a State court under subsection (f).

''(d) EXPERT PANEL REVIEW AND EARLY OFFER GUIDELINES.—

''(1) IN GENERAL.—Prior to the submission of any dispute concerning injuries allegedly caused by health care providers to an administrative health care tribunal under this section, such allegations shall first be reviewed by an expert panel.

''(2) COMPOSITION.—

''(A) IN GENERAL.—An expert panel under this subsection shall be composed of 3 medical experts (either physicians or health care professionals) and 3 attorneys to be appointed by the head of the State agency responsible for health.

''(B) LICENSURE AND EXPERTISE.—Each physician or health care professional appointed to an expert panel under subparagraph (A) shall—

''(i) be appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(ii) typically treat the condition, make the diagnosis, or provide the type of treatment that is under review.

''(C) INDEPENDENCE.—

''(i) IN GENERAL.—Subject to clause (ii), each individual appointed to an expert panel under this paragraph shall—

''(I) not have a material familial, financial, or professional relationship with a party involved in the dispute reviewed by the panel; and

''(II) not otherwise have a conflict of interest with such a party.

''(ii) EXCEPTION.—Nothing in clause (i) shall be construed to prohibit an individual who has staff privileges at an institution where the treatment involved in the dispute was provided from serving as a member of an expert panel merely on the basis of such affiliation, if the affiliation is disclosed to the parties and neither party objects.

''(D) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

''(i) IN GENERAL.—In a dispute before an expert panel that involves treatment, or the provision of items or services—

''(I) by a physician, the medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as a physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

"(II) by a health care professional other than a physician, at least two medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment under review, and, if determined appropriate by the State agency, the third medical expert shall be a practicing health care professional (other than such a physician) of such a same or similar specialty.

"(ii) PRACTICING DEFINED.—In this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days a week.

"(E) PEDIATRIC EXPERTISE.—In the case of dispute relating to a child, at least 1 medical

expert on the expert panel shall have expertise described in subparagraph (D)(i) in pediatrics.

''(3) DETERMINATION.—After a review under paragraph (1), an expert panel shall make a determination as to the liability of the parties involved and compensation.

''(4) ACCEPTANCE.—If the parties to a dispute before an expert panel under this subsection accept the determination of the expert panel concerning liability and compensation, such compensation shall be paid to the claimant and the claimant shall agree to forgo any further action against the health care providers involved.

''(5) FAILURE TO ACCEPT.—If any party decides not to accept the expert panel's determination, the matter shall be referred to an administrative health care tribunal created pursuant to this section.

''(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

''(1) IN GENERAL.—Upon the failure of any party to accept the determination of an expert panel under subsection (d), the parties shall have the right to request a hearing concerning the liability or compensation involved by an administrative health care tribunal established by the State involved.

''(2) REQUIREMENTS.—In establishing an administrative health care tribunal under this section, a State shall—

''(A) ensure that such tribunals are presided over by special judges with health care expertise;

''(B) provide authority to such judges to make binding rulings, rendered in written decisions, on standards of care, causation, compensation, and related issues with reliance on independent expert witnesses commissioned by the tribunal;

''(C) establish negligence as the legal standard for the tribunal;

''(D) allow the admission into evidence of the recommendation made by the expert panel under subsection (d); and

''(E) provide for an appeals process to allow for review of decisions by State courts.

''(f) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

''(1) RIGHT TO FILE.—If any party to a dispute before a health care tribunal under subsection (e) is not satisfied with the determinations of the tribunal,

the party shall have the right to file their claim in a State court of competent jurisdiction.

''(2) FORFEIT OF AWARDS.—Any party filing an action in a State court in accordance with paragraph (1) shall forfeit any compensation award made under subsection (e).

''(3) ADMISSIBILITY.—The determinations of the expert panel and the administrative health care tribunal pursuant to subsections (d) and (e) with respect to a State court proceeding under paragraph (1) shall be admissible into evidence in any such State court proceeding.

''(g) DEFINITION.—In this section, the term 'health care provider' has the meaning given such term for purposes of part A of title VII.

''(h) FUNDING.—

''(1) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of Federal payments made to the State under section 1903(a) of the Social Security Act or section 1939(b)of such Act (in the case of fiscal year 2010 or any fiscal year thereafter) for the first fiscal year for which such grant is awarded shall be increased by an amount equal to 1 percent of of the total amount of

such payments made to the State for the preceding fiscal year under such 1903(a) or 1939(b) (as applicable) for purposes of carrying out this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such sums as may be necessary for purposes of making payments to States pursuant to paragraph (1).''.

TITLE VII—HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

SEC. 701. PURPOSE.

It is the purpose of this subtitle to promote the utilization of health record banking by improving the coordination of health information through an infrastructure for the secure and authorized exchange and use of healthcare information.

SEC. 702. HEALTH RECORD BANKING.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations to pro-

vide for the certification and auditing of the banking of electronic medical records.

(b) GENERAL RIGHTS.—An individual who has a health record contained in a health record bank shall maintain ownership over the health record and shall have the right to review the contents of the record.

SEC. 703. APPLICATION OF FEDERAL AND STATE SECURITY AND CONFIDENTIALITY STANDARDS.

(a) IN GENERAL.—Current Federal security and confidentiality standards and State security and confidentiality laws shall apply to this subtitle until such time as Congress acts to amend such standards.

(b) DEFINITIONS.—In this section:

(1) CURRENT FEDERAL SECURITY AND CONFIDENTIALITY STANDARDS.—The term ''current Federal security and confidentiality standards'' means the Federal privacy standards established pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and security standards established under section 1173(d) of the Social Security Act (42 U.S.C. 1320d–2(d)).

(2) STATE SECURITY AND CONFIDENTIALITY LAWS.—The term ''State security and confidentiality laws'' means State laws and regulations relating to

the privacy and confidentiality of individually identifiable health information or to the security of such information.

(3) STATE.—The term ''State'' has the meaning given such term for purposes of title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

Subtitle B—Promoting the Use of Health Information Technology to Better Coordinate Health Care

SEC. 711. SAFE HARBORS TO ANTIKICKBACK CIVIL PENALTIES AND CRIMINAL PENALTIES FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES.

(a) FOR CIVIL PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(4) For purposes of this subsection, inducements to reduce or limit services described in paragraph (1) shall not include the practical or other advantages resulting from health information technology or related installation, maintenance, support, or training services.''; and

(2) in subsection (i), by adding at the end the following new paragraph:

''(8) The term 'health information technology' means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.''.

(b) FOR CRIMINAL PENALTIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended—

(1) in subsection (b)(3)—

(A) in subparagraph (G), by striking ''and'' at the end;

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

(iii) by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following new subparagraph:

''(J) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(i)(8), or related installation, maintenance, support or training services) made to a person by a specified entity (as defined in subsection (g)) if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

''(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

''(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration solicited or received (or offered or paid) and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

''(iii) the specified entity providing the remuneration (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.''; and

(2) by adding at the end the following new subsection:

''(g) SPECIFIED ENTITY DEFINED.—For purposes of subsection (b)(3)(J), the term 'specified entity' means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering

the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.''.

(c) EFFECTIVE DATE AND EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1128A(b)(4) or section 1128B(b)(3)(J) of such Act, as added by subsections (a)(1) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(d) STUDY AND REPORT TO ASSESS EFFECT OF SAFE HARBORS ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of each of the safe harbors described in

paragraph (3). In particular, the study shall examine the following:

(A) The effectiveness of each safe harbor in increasing the adoption of health information technology.

(B) The types of health information technology provided under each safe harbor.

(C) The extent to which the financial or other business relationships between providers under each safe harbor have changed as a result of the safe harbor in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under each safe harbor.

(2) REPORT.—Not later than 3 years after the effective date described in subsection (c)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

(3) SAFE HARBORS DESCRIBED.—For purposes of paragraphs (1) and (2), the safe harbors described in this paragraph are—

(A) the safe harbor under section 1128A(b)(4) of such Act (42 U.S.C. 1320a–7a(b)(4)), as added by subsection (a)(1); and

(B) the safe harbor under section 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a–7b(b)(3)(J)), as added by subsection (b).

SEC. 712. EXCEPTION TO LIMITATION ON CERTAIN PHYSICIAN REFERRALS (UNDER STARK) FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES TO HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

''(6) INFORMATION TECHNOLOGY AND TRAINING SERVICES.—

''(A) IN GENERAL.—Any nonmonetary remuneration (in the form of health information technology or related installation, maintenance, support or training services) made by a specified entity to a physician if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

''(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

''(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration made and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

''(iii) the specified entity (or a representative of such entity) has not taken any action to disable any basic feature of

any hardware or software component of such remuneration that would permit interoperability.

''(B) HEALTH INFORMATION TECHNOLOGY DEFINED.—For purposes of this paragraph, the term 'health information technology' means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.

''(C) SPECIFIED ENTITY DEFINED.—For purposes of this paragraph, the term 'specified entity' means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.''.

(b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1877(b)(6) of such Act, as added by subsection (a), if the conditions described in such section, with respect to such transaction, are met.

(c) STUDY AND REPORT TO ASSESS EFFECT OF EXCEPTION ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of the exception under section 1877(b)(6) of such Act (42 U.S.C. 1395nn(b)(6)), as added by subsection (a). In particular, the study shall examine the following:

(A) The effectiveness of the exception in increasing the adoption of health information technology.

(B) The types of health information technology provided under the exception.

(C) The extent to which the financial or other business relationships between providers under the exception have changed as a result of the exception in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under the exception.

(2) REPORT.—Not later than 3 years after the effective date described in subsection (b)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

SEC. 713. RULES OF CONSTRUCTION REGARDING USE OF CONSORTIA.

(a) APPLICATION TO SAFE HARBOR FROM CRIMINAL PENALTIES.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding after and below subparagraph (J), as added by section 711(b)(1), the following: ''For purposes of subparagraph (J), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from forming a consortium composed of health care providers, payers, em-

ployers, and other interested entities to collectively purchase and donate health information technology, or from offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

(b) APPLICATION TO STARK EXCEPTION.—Paragraph (6) of section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as added by section 712(a), is amended by adding at the end the following new subparagraph:

''(D) RULE OF CONSTRUCTION.—For purposes of subparagraph (A), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from—

''(i) forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology; or

''(ii) offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

TITLE VIII—MISCELLANEOUS

SEC. 801. DEDICATION OF MEDICAID AND REVENUE SAVINGS TO STRENGTHENING THE FINANCIAL SOLVENCY OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND.

The third sentence of section 1817(a) of the Social Security Act (42 U.S.C. 1395(i)) is amended—

(1) in paragraph (1), by striking ''and'' at the end;

(2) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(3) the revenues made available as a result of the amendments to title XIX and the Internal Revenue Code of 1986 made by the Universal Health Care Choice and Access Act (as determined by the Secretary of the Treasury).''.

SEC. 802. HEALTH CARE CHOICE FOR VETERANS.

Beginning not later than 2 years after the date of the enactment of this Act, the Secretary of Veterans Affairs shall—

(1) permit veterans, and survivors and dependents of veterans, who are eligible for health care and services under the laws administered by the Secretary to receive such care and services through such

non-Department of Veterans Affairs providers and facilities as the Secretary shall approve for purposes of this section; and

(2) pursuant to such procedures as the Secretary of Veteran Affairs shall prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to veterans, and such survivors and dependents, at such rates as the Secretary shall specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

SEC. 803. HEALTH CARE CHOICE FOR INDIANS.

(a) IN GENERAL.—Beginning not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) permit Indians who are eligible for health care and services under a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (and any such other individuals who are so eligible as the Secretary may specify), to

receive such care and services through such non- Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization providers and facilities as the Secretary shall approve for purposes of this section; and

(2) pursuant to such procedures as the Secretary of Health and Human Services shall prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to Indians and individuals described in paragraph (1), at such rates as the Secretary shall specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

(b) DEFINITIONS.—In this section, the terms ''Indian'', ''Indian Health Program'', ''Indian Tribe'', ''Tribal Organization'', and ''Urban Indian Organization'' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

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